

U.S. ARMY SERGEANTS MAJOR ACADEMY (BNCOC)

L337/ THE ARMY HEALTH PROMOTION PROGRAM
AT THE UNIT

OCT 04



Stand Alone Common Core

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TRAINING SUPPORT PACKAGE (TSP)

TSP Number / Title	L337/ THE ARMY HEALTH PROMOTION PROGRAM AT THE UNIT
Effective Date	01 Oct 2004
Supersedes TSP(s) / Lesson(s)	None
TSP Users	600-BNCOC, Basic Noncommissioned Officer Course
Proponent	The proponent for this document is the Sergeants Major Academy.
Improvement Comments	<p>Users are invited to send comments and suggested improvements on DA Form 2028, <i>Recommended Changes to Publications and Blank Forms</i>. Completed forms, or equivalent response, will be mailed or attached to electronic e-mail and transmitted to:</p> <p>COMDT USASMA ATTN ATSS DC BLDG 11291 BIGGS FIELD FORT BLISS, TX 79918-8002</p> <p>Telephone (Comm) (915) 568-8875 Telephone (DSN) 978-8875</p> <p>E-mail: atss-dcd@bliss.army.mil</p>
Security Clearance / Access	Unclassified
Foreign Disclosure Restrictions	FD5. This product/publication has been reviewed by the product developers in coordination with the USASMA foreign disclosure authority. This product is releasable to students from all requesting foreign countries without restrictions.

PREFACE**Purpose**

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

<u>Task Number</u>	<u>Task Title</u>
071-990-0007	Implement a Total Fitness Program in a Company
071-990-0009	Implement an Individual Total Fitness Program

**This TSP
Contains**

TABLE OF CONTENTS

	<u>PAGE</u>
Preface	2
Lesson Section I Administrative Data	4
Section II Introduction.....	8
Terminal Learning Objective - Implement the Army Health Promotion Program at the unit level.....	9
Section III Presentation	10
Enabling Learning Objective A - Explain the goals and objectives of the Army Health Promotion Program.	10
Enabling Learning Objective B - Explain the components of the Army Health Promotion Program.	12
Section IV Summary.....	28
Section V Student Evaluation.....	29
Appendix A - Viewgraph Masters A -	1
Appendix B - Test(s) and Test Solution(s) (N/A) B -	1
Appendix C - Practical Exercises and Solutions (N/A) C -	1
Appendix D - Student Handouts D -	1

THE ARMY HEALTH PROMOTION PROGRAM AT THE UNIT LEVEL
L337 / Version 1
01 Oct 2004

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson	<u>Course Number</u> 600-BNCOC	<u>Version</u> 1	<u>Course Title</u> Basic Noncommissioned Officer Course
Task(s) Taught(*) or Supported	<u>Task Number</u> 071-990-0007	<u>Task Title</u> Implement a Total Fitness Program in a Company	
	071-990-0009	Implement an Individual Total Fitness Program	
Reinforced Task(s)	<u>Task Number</u> None	<u>Task Title</u>	
Academic Hours	The academic hours required to teach this lesson are as follows:		
		<u>Resident Hours/Methods</u> 2 hr / Conference / Discussion	
	Test	0 hrs	
	Test Review	0 hrs	
	Total Hours:	2 hrs	
Test Lesson Number	<u>Hours</u> Testing (to include test review)	<u>Lesson No.</u> 3	<u>Lesson No.</u> E303
Prerequisite Lesson(s)	<u>Lesson Number</u> None	<u>Lesson Title</u>	
Clearance Access	Security Level: Unclassified Requirements: There are no clearance or access requirements for the lesson.		
Foreign Disclosure Restrictions	FD5. This product/publication has been reviewed by the product developers in coordination with the USASMA foreign disclosure authority. This product is releasable to students from all requesting foreign countries without restrictions.		

References

<u>Number</u>	<u>Title</u>	<u>Date</u>	<u>Additional Information</u>
AR 600-63	ARMY HEALTH PROMOTION	28 Apr 1996	Student Handout 2
AR 600-85	ARMY SUBSTANCE ABUSE PROGRAM (ASAP)	1 Oct 2001	Student Handout 3

Student Study Assignments

Before class--

- Read Student Handouts 1 and 2.

During class--

- Participate in the class discussion.

After class--

- Turn in recoverable materials.

Instructor Requirements

1:16, BNCOC graduate, ITC, and SGITC qualified.

Additional Support Personnel Requirements

<u>Name</u>	<u>Stu Ratio</u>	<u>Qty</u>	<u>Man Hours</u>
None			

Equipment Required for Instruction

<u>ID Name</u>	<u>Stu Ratio</u>	<u>Instr Ratio</u>	<u>Spt</u>	<u>Qty</u>	<u>Exp</u>
441-06 LCD PROJECTION SYSTEM	1:16	1:1	No	1	No
559359 SCREEN PROJECTION	1:16	1:1	No	1	No
673000T101700 PROJECTOR, OVERHEAD, 3M	1:16	1:1	No	1	No
702101T134520 DELL CPU, MONITOR, MOUSE, KEYBOARD	1:16	1:1	No	1	No
703500T102257 DESKTOP/EPSON PRINTER	1:16	1:1	No	1	No
7110-00-T81-1805 DRY ERASE BOARD	1:16	1:1	No	1	No
7510-01-424-4867 EASEL, (STAND ALONE) WITH PAPER	1:16	1:1	No	1	No
SNV1240262544393 36 - INCH COLOR MONITOR W/REMOTE CONTROL AND LUXOR STAND	1:16	1:1	No	1	No
SOFTWARE-2 WINDOWS XP, LATEST GOVERNMENT APPROVED VERSION	1:16	1:1	No	1	No

* Before Id indicates a TADSS

**Materials
Required****Instructor Materials:**

- TSP.
- AR 600-63.
- VGT-1 thru VGT-23.
- Any equipment required by the NCOA's SOP.

Student Materials:

- Student Handouts 1 and 2.
- Pen or pencil and writing paper.
- Any materials required by the NCOA's SOP.

**Classroom,
Training Area,
and Range
Requirements**

GEN INSTRUCT BLDG (CLASSROOM SIZE 40X40 PER STU)

**Ammunition
Requirements**

<u>ID</u>	<u>Name</u>	<u>Exp</u>	<u>Stu Ratio</u>	<u>Instr Ratio</u>	<u>Spt Qty</u>
None					

**Instructional
Guidance**

NOTE: Before presenting this lesson, instructors must thoroughly prepare by studying this lesson and identified reference material.

Before class--

- Read and study all TSP material and be ready to conduct the class.
- This TSP has questions throughout to check on learning or generate discussion among the group members. You may add any questions you deem necessary to bring a point across to the group or expand on any matter discussed.
- You must know the information in this TSP well enough to teach from it, not read from it.
- Issue Student Handout 1 and all recoverable materials NLT three days prior to class.

During class--

- Conduct the class in accordance with this TSP.

After class--

- Collect all recoverable materials after the examination of this lesson.
- Report any lesson discrepancies to the Senior Instructor.

**Proponent
Lesson Plan
Approvals**

<u>Name</u>	<u>Rank</u>	<u>Position</u>	<u>Date</u>
/s/ McLaughlin, John A.	GS09	Training Specialist	9 AUG 04
/s/ King, Phillip W.	GS11	Course Manager, B/ANCOC	9 AUG 04
/s/ Bennett-Green, Agnes D.	SGM	Chief, B/ANCOC	9 AUG 04
/s/ Lemon, Marion	SGM	Chief, CDDD	9 AUG 04

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SECTION II. INTRODUCTION

Method of Instruction: <u>Conference / Discussion</u>
Technique of Delivery: <u>Small Group Instruction (SGI)</u>
Instructor to Student Ratio is: <u>1:16</u>
Time of Instruction: <u>5 mins</u>
Media: <u>None</u>

Motivator

The Army has long recognized the correlation between health, unit readiness, and organizational effectiveness. As a result, the Army has established health promotion policies applicable to all Army activities. The Army Health Promotion Program (AHPP) includes the soldier, his family members, civil service employees, and military retirees. AR 600-63 provides both the structure and guidelines for the maintenance of the AHPP. This regulation also outlines the policy, responsibilities, and implementation procedures for the program. This lesson provides current doctrine about the program and your role in support of its initiatives. At the end of the health promotion program lessons, you will have an in-depth understanding of the Army's Health Promotion Program and be fully capable of implementing this valuable "combat multiplier" into your units.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Implement the Army Health Promotion Program at the unit level.
Conditions:	As a small unit leader in a company or battalion level unit.
Standards:	Implemented the Army Health Promotion Program IAW AR 600-63 (Student Handout 2).

Safety Requirements

None

Risk Assessment Level

Low

Environmental Considerations

NOTE: It is the responsibility of all soldiers and DA civilians to protect the environment from damage.

None

Evaluation

“During this course you will take a 50-question written examination. The examination will include questions on the ELOs and TLO from this lesson. You must correctly answer at least 35 questions to receive a GO. A GO is a graduation requirement.”

Instructional Lead-In

As a section sergeant you are a leader of a squad. Therefore you have inherited responsibilities. This lesson will provide you with knowledge about the Army Health Promotion Program (AHPP). We will not go into too much depth, but you will become familiar with the Army Regulation 600-63. This regulation is your future reference for the AHPP. At some point in your career you will be required to provide your commander input concerning your unit's Health Promotion Program, this lesson will prepare you for this.

SECTION III. PRESENTATION

NOTE: Inform the students of the Enabling Learning Objective requirements.

A. ENABLING LEARNING OBJECTIVE

ACTION:	Explain the goals and objectives of the Army Health Promotion Program.
CONDITIONS:	As a small unit leader in a classroom, given Student Handout 2.
STANDARDS:	Explained the goals and objectives of the Army Health Promotion Program IAW AR 600-63 (Student Handout 2).


1. Learning Step / Activity 1. Explain the Goals and Objectives of the Army Health Promotion Program

Method of Instruction: Conference / Discussion
 Technique of Delivery: Small Group Instruction (SGI)
 Instructor to Student Ratio: 1:16
 Time of Instruction: 10 mins
 Media: VGT-1 and VGT-2


Let's look at the goal of the Army's Health Promotion Program.

NOTE: Ask the students what is the goal of the Army Health Promotion Program.

SHOW VGT-1, GOAL



Goal



Maximize--

- **Readiness**
- **Combat Efficiency**
- **Work Performance.**

L337/OCT 04/VGT-1
Basic Noncommissioned Officer Course

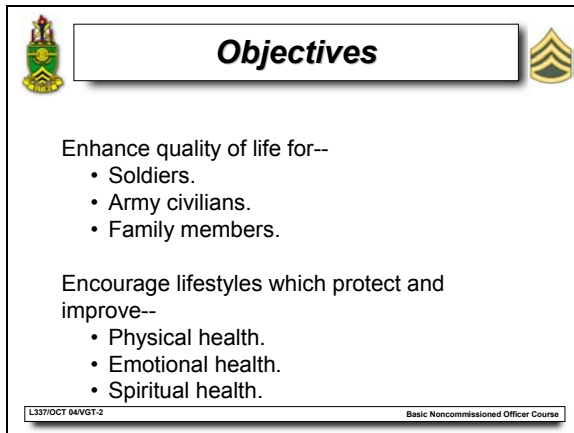
Ref: SH-2, p 1, para 1-4a

REMOVE VGT-1

Objectives

The objectives of the Army Health Promotion Program (AHPP) encompass a variety of activities designed to improve or protect the health of the total force. These activities include physical, emotional, spiritual, and social dimensions. The activities represent positive actions whose sum effect improves the unit's performance through enhanced individual well-being.

SHOW VGT- 2, OBJECTIVES



Objectives

Enhance quality of life for--

- Soldiers.
- Army civilians.
- Family members.

Encourage lifestyles which protect and improve--

- Physical health.
- Emotional health.
- Spiritual health.

L337/OCT 04/VGT-2 Basic Noncommissioned Officer Course

Ref: SH-2, p 1, para 1-4a and 1-4b

NOTE: Discuss the Army objectives in a general sense allowing the students to reflect and respond with their own experiences.

REMOVE VGT- 2

CHECK ON LEARNING:

QUESTION: What is the goal of the Army Health Promotion Program?

ANSWER: To maximize readiness, combat efficiency, and work performance.

Ref: SH-2, p 1, para 1-4a

B. ENABLING LEARNING OBJECTIVE

ACTION:	Explain the components of the Army Health Promotion Program.
CONDITIONS:	As a small unit leader in a classroom, given Student Handout 2.
STANDARDS:	Explained the components of the Army Health Promotion Program IAW AR 600-63 (Student Handout 2).

1. Learning Step / Activity 1. Explain the Implementation of the Army Health Promotion Program


Method of Instruction: Conference / Discussion
 Technique of Delivery: Small Group Instruction (SGI)
 Instructor to Student Ratio: 1:16
 Time of Instruction: 1hr 30 mins
 Media: VGT-3 thru VGT-23

Components


To functionally describe the AHPP, AR 600-63 states that the components of health promotion consist of all activities for members of the Total Army Family in the areas as shown on the next two VGTs.

NOTE: Have the students discuss how the various components listed on VGT-3 and VGT-4 impact on the health promotion program goal referred to in VGT-1.

SHOW VGT- 3, COMPONENTS



Components





- Antitobacco.
- Physical conditioning.
- Weight control.
- Nutrition.
- Stress Management.

L337/OCT 04/VGT-3
Basic Noncommissioned Officer Course

Ref: SH-2, p 1, para 1-4c

REMOVE VGT- 3

SHOW VGT- 4, COMPONENTS (CONT)

Components (cont)

- Army Substance Abuse Program (ASAP).
- Early identification of hypertension.
- Suicide prevention.
- Spiritual fitness.
- Oral health.



L337/OCT 04/VGT-4 Basic Noncommissioned Officer Course

Ref: SH-2, p 1, para 1-4c

REMOVE VGT- 4**Antitobacco**

Now let's discuss how the Army's leaders implement the health promotion policies and the components of the AHPP we saw on the last two VGTs. We will discuss antitobacco first.

NOTE: Generate discussion on the Army's antitobacco policy by asking the students the following question: What are the responsibilities for implementing the antitobacco policy established by the Army? Expect the discussion to focus on controlling smoking in DA controlled areas. AR 600-63, Chapter 4, provides current guidance on this subject.

SHOW VGT-5, ANTITOBACCO RESPONSIBILITIES

Antitobacco Responsibilities

- Commanders control tobacco products during initial entry training.
- Commanders encourage antitobacco activities.
- Health care providers aggressively support anti-tobacco activities during physical and dental examinations.
- Leaders enforce DA policy regarding smoking in the workplace.

L337/OCT 04/VGT-5 Basic Noncommissioned Officer Course

Ref: SH-2, p 3, para 2-2


The Army bases its antitobacco policies on research by the American Cancer Society and the National Center for Disease Control. The data shows conclusively that tobacco is harmful and disruptive in the American workplace. Smoking tobacco impairs readiness and physical fitness by increasing illness, premature death, absenteeism, and health care costs. Establishing a smoke-free environment that supports abstinence and discourages tobacco use enhances overall readiness.

REMOVE VGT-5


Fitness Responsibilities

Next we will discuss policies on physical fitness. Physical fitness includes factors that allow individuals to function effectively during physical and mental work and still have energy left to handle any emergency. A sound physical fitness program includes cardio respiratory fitness, muscular strength and endurance, flexibility, and body composition. To see what the responsibilities are for implementing the Army Physical Fitness Program, let's look at VGT-6.

SHOW VGT-6, FITNESS RESPONSIBILITIES



Fitness Responsibilities



Commanders and supervisors will--

- establish and conduct physical fitness programs for soldiers.
- encourage regular exercise by civilian employees.

All AC and RC soldiers will--

- participate in physical fitness training year round.
- complete medical screening on 40th birthday.

L337/OCT 04/VGT-6 Basic Noncommissioned Officer Course

Ref: SH-2, p 3, para 2-3



NOTE: Guide the discussion so it touches on the policy regarding a physical fitness program for civilian employees.

REMOVE VGT-6

Nutrition and Weight Control

Now we will proceed to policies affecting nutrition and weight control. Nutrition and weight control integration is necessary for the health and welfare of an individual. The policies that support these components are straightforward in their intent. The Army believes nutrition information, education, and counseling programs will promote optimal fitness in the military population. Leaders should work closely with qualified health care professionals in promoting total fitness. The next VGT shows references that provide guidelines and standards for meeting Army policy objectives for nutrition and weight control.

SHOW VGT-7, GUIDANCE ON NUTRITION AND WEIGHT CONTROL

 Guidance on Nutrition and Weight Control 	
For information on . . .	<u>See AR</u>
• Nutrition	40-25
• Garrison dining facilities	30-1
• Weight control programs	600-9

L337/OCT 04/VGT-7 Basic Noncommissioned Officer Course

Ref: SH-2, p 3, para 2-4 and 2-5

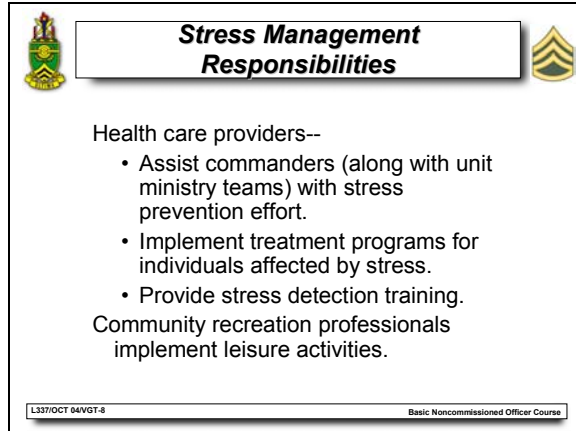
As section sergeants you need to be familiar with the ARs referenced on this VGT and use them to monitor your soldiers' proper body weight, body composition, and personal appearance standards. Responsibilities include establishing educational and motivational programs that encourage persons to attain and maintain approved weight and appearance standards. AHPP nutrition and weight control programs should include soldiers, Army civilians, family members, and military retirees.

REMOVE VGT-7

Stress Management

Next we will look at the role health care providers and community recreation personnel play in stress management.

SHOW VGT-8, STRESS MANAGEMENT RESPONSIBILITIES



The slide is titled "Stress Management Responsibilities" in a bold, italicized font, centered at the top. It is flanked by two military crests. The main content is divided into two sections: "Health care providers--" and "Community recreation professionals". The first section includes a bulleted list of three responsibilities: assisting commanders with stress prevention, implementing treatment programs, and providing stress detection training. The second section states that community recreation professionals implement leisure activities. At the bottom, there is a small footer with the text "L337/OCT 04/VGT-8" and "Basic Noncommissioned Officer Course".

Stress Management Responsibilities

Health care providers--

- Assist commanders (along with unit ministry teams) with stress prevention effort.
- Implement treatment programs for individuals affected by stress.
- Provide stress detection training.

Community recreation professionals implement leisure activities.

L337/OCT 04/VGT-8 Basic Noncommissioned Officer Course

Ref: SH-2, p 4, para 2-7


As the VGT shows, health care providers and community recreation personnel play a big role in stress management. Stress management taps all resources from a person's environment, both external and internal. Stress management closely relates to the Army's suicide prevention program. The focus of the stress management program is to increase the ability of persons, to include Army civilians, to cope with stress.

REMOVE VGT-8


Army Substance Abuse Program

A very important issue that affects the Total Army Family is that of alcohol and drug addiction. The Army addresses this issue through the Army Substance Abuse Program (ASAP). The previous name of this program was Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). AR 600-85, dated 1 October 2001 renamed the program Army Substance Abuse Program and updated guidance and procedures under this regulation for ASAP. We will use AR 600-85 to reference this program until AR 600- 63 get updated. The ASAP mission is to strengthen the overall fitness and effectiveness of the Army's total workforce and to enhance the combat readiness of its soldiers. The following are the objectives of the ASAP:

SHOW VGT-9, ASAP OBJECTIVES



ASAP Objectives





- Increase individual fitness and overall unit readiness.
- Provide services, which are adequate and responsive to the needs of the total force.
- Emphasize alcohol and other drug abuse deterrence, prevention, education, and treatment.
- Implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers.
- Restore to duty those substance-impaired soldiers who have the potential for continued service.

L337/OCT 04VGT-9Basic Noncommissioned Officer Course

Ref: SH-3, p 8, para 1-30

REMOVE VGT-9



SHOW VGT-10, ASAP OBJECTIVES, cont

ASAP Objectives, cont

- Provide effective alcohol and other prevention and education at all levels of command, and encourage commanders to provide alcohol and drug-free activities.
- Ensure all military and civilian personnel assigned to ASAP staffs are appropriately trained and experienced to accomplish their mission.
- Achieve maximum productivity and reduce absenteeism and attrition among DA civilian employees by reducing the effects of the abuse of alcohol and other drugs.

L337/OCT 04VGT-10 Basic Noncommissioned Officer Course

Ref: SH-3, p 8, para 1-30

REMOVE VGT 10**SHOW VGT-11, ASAP OBJECTIVES, cont**

ASAP Objectives, cont

- Improve readiness by extending services to the total Army.
- Ensure quality customer service.

L337/OCT 04VGT-11 Basic Noncommissioned Officer Course

Ref: SH-3, p 8, para 1-30

REMOVE VGT-11


The ASAP component is a command program that emphasizes readiness and personal responsibility. The ultimate decision regarding separation or retention of abusers is the responsibility of the soldier's chain of command. The command role in prevention, biochemical testing, early identification of problems, rehabilitation, and administrative or judicial actions is essential. Commanders will ensure all officials and supervisors support the ASAP. You as a small unit leader must support your commander in implementation of the ASAP. AHPP is a requirement for all installations, communities, and activities according to AR 600-85.

The ASAP is not a punitive measure for commanders and supervisors to resort to. It is an opportunity for soldiers identified as substance abusers who warrant retention to seek and receive rehabilitation according to AR 600-85. Commanders should aggressively implement this activity. They must prepare to take prompt action, regardless of rank or grade, if there is a suspicion of alcohol or other drug abuse. Commanders must also give adequate publicity to the alcohol and drug policy to ensure all eligible persons, to include civilians and family members, are aware of the Army's programs.


Hypertension

The next component we will discuss is hypertension. Health care providers play a major role in combating hypertension. In most cases the soldier or family member does not realize the need for treatment. Early detection and treatment of hypertension is, at best, just a control measure for this health risk.

SHOW VGT-12, HYPERTENSION IDENTIFICATION RESPONSIBILITIES



Hypertension Identification Responsibilities



Health Care Providers will--

- Provide information to soldiers.
- Develop and implement protocols for referring individuals with significant health risk factors.
- Conduct cardiovascular screening for soldiers 40 and over.
- Provide basic information to commanders, supervisors, or counselors outside the health care setting.
- Develop and implement annual blood pressure measurements for soldiers and selected family members.

L337/OCT 04/VGT-10
Basic Noncommissioned Officer Course

Ref: SH-2, p 4, para 2-11b

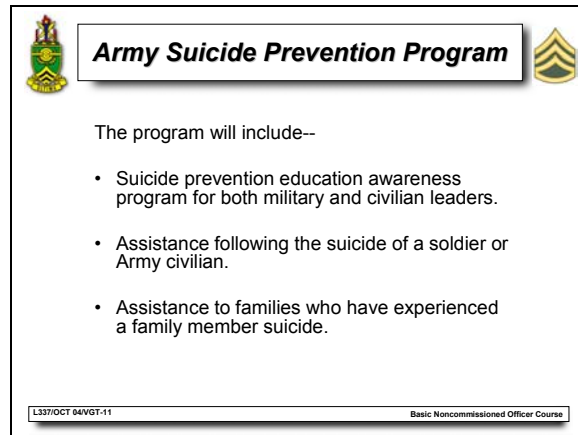
NOTE: Discuss the unit leadership's involvement and responsibilities for this component. One concern is that the student recognizes that keeping accurate records on individuals with significant health risk factors will contribute significantly to mission planning. The students also must know what their responsibilities are to the AHPP. They must ensure individuals identified as engaging in health risk behaviors understand how those behaviors impact on their overall health.

REMOVE VGT-12

Suicide Prevention

Our next component of the AHPP is suicide prevention, which is every leader's concern. Every installation, community, and activity must establish a suicide prevention program to enhance unit readiness. As a minimum, a community or separate activity suicide prevention program will include the information on the next VGT.

SHOW VGT-13, ARMY SUICIDE PREVENTION PROGRAM



Ref: SH-2, p 4, para 2-8 and Chapter 5

NOTE: Discuss the need for a suicide prevention program and the role professionals have in family assistance.

REMOVE VGT-13

Spiritual Fitness


The Army recognizes the multidimensional makeup of every human being and supports a total person concept when dealing with personnel. In this total person concept, the Army extends spiritual fitness development opportunities to every soldier. Spiritual fitness is the next component of the AHPP we will discuss.

QUESTION: What is spiritual fitness?


ANSWER: The development of those personal qualities needed to sustain a person in times of stress, hardship, and tragedy. These qualities comes from religious, philosophical, or human values and form the basic character, disposition, decision making and integrity.

Ref: SH-2, p 15, Section II, Terms

Let's look at the spiritual fitness responsibilities.

SHOW VGT- 14, SPIRITUAL FITNESS RESPONSIBILITIES


Spiritual Fitness Responsibilities



Commanders and leaders will--

- Develop awareness of diversity.
- Develop soldier and family support activities.
- Provide for self-development activities.

All soldiers and Army civilians live by--

- Professional Army ethics.
- Individual values that support and sustain the Army way of life.

L337/OCT 04VGT-12
Basic Noncommissioned Officer Course


Ref: SH-2, p 4, para 2-9

Commanders must not advocate religion as part of their encouragement and support for this component. The practice of religion when it relates to spiritual fitness is a matter of personal decision for each individual. Leaders must ensure that each soldier is free to worship as he may choose without fear of punishment for his choice.


REMOVE VGT-14

BREAK: TIME: 0:50 to 01:00 (end of first hour)

TIME: 01:00 to 01:20 (continue learning step activity 1, ELO B)

Dental Fitness**SHOW VGT-15, ORAL HEALTH PROMOTION**


Oral Health Promotion



- Require minimum level of dental health for active duty soldiers.
- Provide dental insurance information for family members.
- Evaluate community oral health through HRA questionnaire.
- Integrate hypertension screening and tobacco counseling into dental exams.

L337/OCT 04VGT-13
Basic Noncommissioned Officer Course

Ref: SH-2, pp 4 and 5, para 2-12

The purpose of oral health is to reduce dental disease in the force. The oral health program includes the annual dental examination and the dental fitness classification system. It also includes community-wide dental health education and preventive dentistry. AR 600-63, para 2-12, provides the specifics of the DA oral health fitness program.


REMOVE VGT-15

Physical Examinations


In addition to the ten components we have discussed, health promotion also includes other related activities. They are physical examinations, health risk assessments, physical fitness and recreation facilities, recreation and leisure education and activities, and initiatives promoting social and emotional well-being. The Army has coordinated and integrated many activities into a comprehensive health promotion program called "Fit to Win".

NOTE: Do not spend too much time on VGTs 16 and 17. The intent is to just show the students what the commanders are allowed to do.

SHOW VGT-16, ARMY FIT TO WIN PROGRAM



Army Fit to Win Program





When fully implemented, such an activity should allow commanders to--

- Actively market all aspects of the installation program.
- Conduct community needs assessments in health promotion areas.
- Provide a program of education and consultation to meet identified needs.

L337/OCT 04/VGT-16 Basic Noncommissioned Officer Course

Ref: SH-3, p 5, para 2-16

REMOVE VGT-16

SHOW VGT-17, ARMY FIT TO WIN PROGRAM, CONT



Army Fit to Win Program, cont

- Sustain program participation.
- Support Army-wide collection for program education.
- DA Pam 600-63 (1-13) details operations and education.

L337/OCT 04VGT-17 Basic Noncommissioned Officer Course

Ref: SH-3, p 5, para 2-16

Periodic monitoring of the individual's physical well-being is critical to the success of the AHPP and includes physical examinations, the family fitness program, and the health risk appraisal. The next VGT shows the examination responsibilities of health care providers.

SHOW VGT-18, PHYSICAL EXAMINATION RESPONSIBILITIES

Physical Examination Responsibilities



- Health care providers will conduct physical examinations and a health risk appraisal IAW the procedures of AR 40-501.
- Screen all soldiers age 40 and over for cardiovascular risk as well as other limiting factors as part of their periodic physical examinations and IAW AR 40-501.

L337/OCT 04VGT-18 Basic Noncommissioned Officer Course

Ref: SH-2, p 4, para 2-10

Health care providers conduct physical exams in accordance with the procedures of AR 40-501. However, commanders and leaders should be alert to factors which might suggest a need for an additional screening of the soldier.

REMOVE VGT-18

Health Risk**SHOW VGT-19, HEALTH RISK APPRAISAL RESPONSIBILITIES**

Health Risk Appraisal Responsibilities



Health care providers will--

- Inform individuals of their health risk appraisal profile.
- Use the approved health risk appraisal (survey) to screen for health risk factors.
- Administer a risk appraisal for all enlistees upon entry into the Army.
- Include a risk assessment in periodic physical examinations.

L337/OCT 04/VGT-19 Basic Noncommissioned Officer Course

Ref: SH-2, p 5, para 2-13

NOTE: Have students open AR 600-63 and discuss the commanders' responsibilities as stated in para 2-13e. Reinforce the importance of command involvement in the AHPP and the specific intervals required to meet AHPP requirements.

REMOVE VGT-19**Family Fitness****SHOW VGT-20, FAMILY FITNESS PROGRAM**

Family Fitness Program

This program supports--

- Readiness.
- Leadership.
- Quality of life.
- Sustainment.
- Personnel functions.

L337/OCT 04/VGT-20 Basic Noncommissioned Officer Course


Ref: SH-2, p 5, para 2-14

The policy of the family fitness program simply states that we must promote all aspects of the AHPP and include all family members. All of the activities included in the Army Health Promotion Program apply to the family as well. A family fitness program must support those items listed on this VGT.


REMOVE VGT-20

Fitness and Recreation

SHOW VGT-21, FITNESS AND RECREATION FACILITIES



Fitness and Recreation Facilities



Commanders--

- May use appropriated funds to provide facilities for soldiers and DA civilians.
- Should encourage DA civilians to make maximum use of facilities.
- Establish priorities between soldiers, Army civilians, and family members for the use of physical fitness facilities, consistent with resource availability, mission and training requirements.

L337/OCT 04/VGT-21Basic Noncommissioned Officer Course

Ref: SH-2, p 5, para 2-15

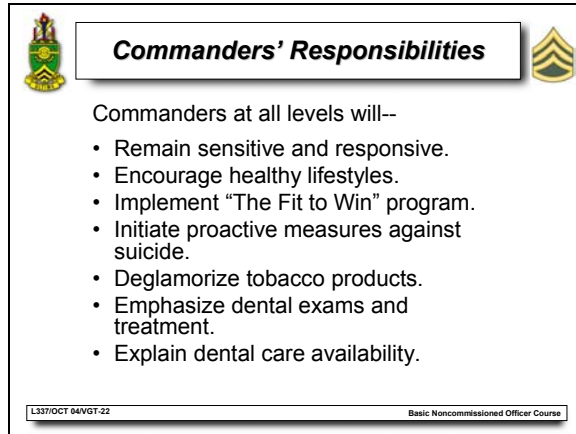
NOTE: Discuss some examples of facilities supported by appropriated funds (post gyms and physical fitness centers) and some by nonappropriated funds (bowling alleys, swimming pools, and tennis courts). Emphasize those community recreation facilities that civilians and family members can use.

REMOVE VGT-21

Commanders' Responsibilities

The next VGT shows the general responsibilities all commanders have for implementing the Army's Health Promotion Program.

SHOW VGT-22, COMMANDERS' RESPONSIBILITIES



Commanders' Responsibilities

Commanders at all levels will--

- Remain sensitive and responsive.
- Encourage healthy lifestyles.
- Implement "The Fit to Win" program.
- Initiate proactive measures against suicide.
- Deglamorize tobacco products.
- Emphasize dental exams and treatment.
- Explain dental care availability.

L337/OCT 04/VGT-22 Basic Noncommissioned Officer Course

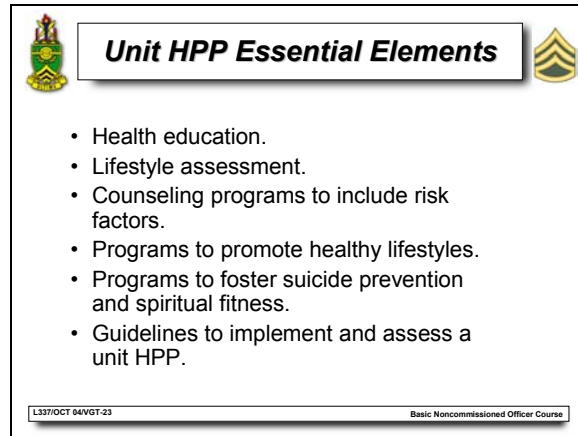
Ref: SH-2, p 2, para 1-21

The significant point on this VGT is command involvement at all levels. A commander's position and role in the command structure give him the responsibility to implement and maintain the program. The commander should conduct periodic unit program inspections, conduct soldier readiness exercises, schedule unit AHPP education classes, etc.

REMOVE VGT-22

AHPP Essential Elements

The efforts of the leaders will determine the success of the AHPP. An effective, comprehensive program should include the essential elements listed on VGT 19.

SHOW VGT-23, UNIT HPP ESSENTIAL ELEMENTS

Ref: SH-2, pp 5 thru 7, Chapter 3

As a section sergeant you can develop a health promotion program using the guidance provided in AR 600-63 and the DA Pam 600-63 series publications. Health promotion policies apply to all Army activities and operating agencies. These health promotion policies encompass physical, emotional, spiritual, and social dimensions to improve unit and organizational performance by enhancing individual well-being.

REMOVE VGT-23

We all know that the commander has the ultimate responsibility to implement the AHPP within his unit. As a minimum, you should help him by making recommendations in designing a battalion/unit level health promotion program.

CHECK ON LEARNING: VGT-3 thru VGT-19 serves as the check on learning for this ELO.

SECTION IV. SUMMARY

Method of Instruction: <u>Conference / Discussion</u>
Technique of Delivery: <u>Small Group Instruction (SGI)</u>
Instructor to Student Ratio: <u>1:16</u>
Time of Instruction: <u>5 mins</u>
Media: <u>None</u>

Check on Learning

QUESTION: What is the goal of the Army Health Promotion Program?

ANSWER: To maximize readiness, combat efficiency, and work performance.

Ref: SH-2, para 1-4a

QUESTION: What are the effects of tobacco use on readiness?

ANSWER: Tobacco use impairs physical fitness, increases illness, absenteeism, premature death, and health care costs.

Ref: SH-2, para 4-1a

QUESTION: Which AR addresses the alcohol and drug abuse prevention and control program (ADAPCP)?

ANSWER: AR 600-85

Ref: SH-2, para 2-6a

Review / Summarize Lesson

This lesson reviewed the Army Health Promotion Program. You also have AR 600-63 and the DA Pam 600-63 series publications to familiarize yourselves with the functional components of the program.

You reviewed the commander and supervisor responsibilities, key steps, and factors for the development of a health promotion program SOP.

Finally, you discussed basic requirements for the implementation and maintenance of the program.

Transition to Next Lesson

None

SECTION V. STUDENT EVALUATION**Testing
Requirements**

NOTE: Describe how the student must demonstrate accomplishment of the TLO. Refer student to the Student Evaluation Plan.

During this course you will take a 50-question written examination. The examination will include questions on the ELOs and TLO from this lesson. You must correctly answer at least 35 questions to receive a GO. A GO is a graduation requirement.

**Feedback
Requirements**

NOTE: Feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

None

Appendix A - Viewgraph Masters**VIEWGRAPHS FOR LESSON 1: L326 version 1**

Enabling Learning Objective A

Learning Step 1

VGT-1, Goal

***Goal*****Maximize--**

- **Readiness**
- **Combat Efficiency**
- **Work Performance.**

VGT-2, Objectives



Objectives



Enhance quality of life for--

- Soldiers.
- Army civilians.
- Family members.
- Retirees.

Encourage lifestyles which protect and improve--

- Physical health.
- Emotional health.
- Spiritual health.

Enabling Learning Objective B

Learning Step 1

VGT-3, Components



Components



- Antitobacco.
- Physical conditioning.
- Weight control.
- Nutrition.
- Stress Management.

VGT-4, Components (cont)

***Components (cont)***

- Alcohol and drug abuse prevention and control.
- Early identification of hypertension.
- Suicide prevention.
- Spiritual fitness.
- Oral health.

VGT-5, Antitobacco Responsibilities



Antitobacco Responsibilities



- Commanders control tobacco products during initial entry training.
- Commanders encourage antitobacco activities.
- Health care providers aggressively support anti-tobacco activities during physical and dental examinations.
- Leaders enforce DA policy regarding smoking in the workplace.

VGT-6, Fitness Responsibilities



Fitness Responsibilities



Commanders and supervisors will--

- establish and conduct physical fitness programs for soldiers.
- encourage regular exercise by civilian employees.

All AC and RC soldiers will--

- participate in physical fitness training year round.
- complete medical screening on 40th birthday.

VGT-7, Guidance on Nutrition and Weight Control

***Guidance on Nutrition and Weight Control***

For information on . . .	<u>See AR</u>
• Nutrition	40-25
• Garrison dining facilities	30-1
• Weight control programs	600-9

VGT-8, Stress Management Responsibilities



Stress Management Responsibilities



Health care providers--

- Assist commanders (along with unit ministry teams) with stress prevention effort.
- Implement treatment programs for individuals affected by stress.
- Provide stress detection training.

Community recreation professionals
implement leisure activities.

VGT-9, ASAP Objectives



ASAP Objectives



- Increase individual fitness and overall unit readiness.
- Provide services, which are adequate and responsive to the needs of the total force.
- Emphasize alcohol and other drug abuse deterrence, prevention, education, and treatment.
- Implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers.
- Restore to duty those substance-impaired soldiers who have the potential for continued service.

VGT-10, ASAP Objectives, cont



ASAP Objectives, cont



- Provide effective alcohol and other prevention and education at all levels of command, and encourage commanders to provide alcohol and drug-free activities.
- Ensure all military and civilian personnel assigned to ASAP staffs are appropriately trained and experienced to accomplish their mission.
- Achieve maximum productivity and reduce absenteeism and attrition among DA civilian employees by reducing the effects of the abuse of alcohol and other drugs.

VGT-11, ASAP Objectives, cont



ASAP Objectives, cont



- Improve readiness by extending services to the total Army.
- Ensure quality customer service.

VGT-12, Hypertension Identification Responsibilities



Hypertension Identification Responsibilities



Health Care Providers will--

- Provide information to soldiers.
- Develop and implement protocols for referring individuals with significant health risk factors.
- Conduct cardiovascular screening for soldiers 40 and over.
- Provide basic information to commanders, supervisors, or counselors outside the health care setting.
- Develop and implement annual blood pressure measurements for soldiers and selected family members.

VGT-13, Army Suicide Prevention Program



Army Suicide Prevention Program



The program will include--

- Suicide prevention education awareness program for both military and civilian leaders.
- Assistance following the suicide of a soldier or Army civilian.
- Assistance to families who have experienced a family member suicide.

VGT-14, Spiritual Fitness Responsibilities



Spiritual Fitness Responsibilities



Commanders and leaders will--

- Develop awareness of diversity.
- Develop soldier and family support activities.
- Provide for self-development activities.

All soldiers and Army civilians live by--

- Professional Army ethics.
- Individual values that support and sustain the Army way of life.

VGT-15, Oral Health Promotion



Oral Health Promotion



- Require minimum level of dental health for active duty soldiers.
- Provide dental insurance information for family members.
- Evaluate community oral health through HRA questionnaire.
- Integrate hypertension screening and tobacco counseling into dental exams.

VGT-16, Army Fit to Win Program



Army Fit to Win Program



When fully implemented, such an activity should allow commanders to--

- Actively market all aspects of the installation program.
- Conduct community needs assessments in health promotion areas.
- Provide a program of education and consultation to meet identified needs.

VGT-17, Army Fit to Win Program, cont



Army Fit to Win Program, cont



- Sustain program participation.
- Support Army-wide collection for program education.
- DA Pam 600-63 (1-13) details operations and education.

VGT-18, Physical Examination Responsibilities



Physical Examination Responsibilities



- Health care providers will conduct physical examinations and a health risk appraisal IAW the procedures of AR 40-501.
- Screen all soldiers age 40 and over for cardiovascular risk as well as other limiting factors as part of their periodic physical examinations and IAW AR 40-501.

VGT-19, Health Risk Appraisal Responsibilities



Health Risk Appraisal Responsibilities



Health care providers will--

- Inform individuals of their health risk appraisal profile.
- Use the approved health risk appraisal (survey) to screen for health risk factors.
- Administer a risk appraisal for all enlistees upon entry into the Army.
- Include a risk assessment in periodic physical examinations.

VGT-20, Family Fitness Program



Family Fitness Program



This program supports--

- Readiness.
- Leadership.
- Quality of life.
- Sustainment.
- Personnel functions.

VGT-21, Fitness and Recreation Facilities



Fitness and Recreation Facilities



Commanders--

- May use appropriated funds to provide facilities for soldiers and DA civilians.
- Should encourage DA civilians to make maximum use of facilities.
- Establish priorities between soldiers, Army civilians, and family members for the use of physical fitness facilities, consistent with resource availability, mission and training requirements.

VGT-22, Commanders' Responsibilities



Commanders' Responsibilities



Commanders at all levels will--

- Remain sensitive and responsive.
- Encourage healthy lifestyles.
- Implement "The Fit to Win" program.
- Initiate proactive measures against suicide.
- Deglamorize tobacco products.
- Emphasize dental exams and treatment.
- Explain dental care availability.

VGT-23, Unit HPP Essential Elements



Unit HPP Essential Elements



- Health education.
- Lifestyle assessment.
- Counseling programs to include risk factors.
- Programs to promote healthy lifestyles.
- Programs to foster suicide prevention and spiritual fitness.
- Guidelines to implement and assess a unit HPP.

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Appendix B - Test(s) and Test Solution(s) (N/A)

Appendix C

FOR LESSON 1: L337 version 1 (N/A)

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HANDOUTS FOR LESSON 1: L337 version 1

This appendix contains the items listed in this table--

Title/Synopsis	Pages
SH-1, Advance Sheet	SH-1-1
SH-2, Extracted Material from AR 600-63, Army Health Promotion	SH-2-1
SH-3, Extracted Material from AR 600-85, Army Substance Abuse Program (ASAP)	SH-3-1

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Student Handout 1

Advance Sheet

Lesson Hours

This lesson consists of 2 hours of conference/discussion.

Overview

This lesson introduces you to the Army Health Promotion Program. The purpose of this lesson is to encourage commitment to an organization's Health Promotion Program and combat readiness.

Learning Objective

Terminal Learning Objective (TLO).

Action:	Implement the Army Health Promotion Program at the unit level.
Conditions:	As a small unit leader in a company or battalion level unit.
Standards:	Implemented the Army Health Promotion Program IAW AR 600-63 (Student Handout 2).

ELO A Explain the goals and objectives of the Army Health Promotion Program.

ELO B Explain the components of the Army Health Promotion Program.

Student Assignments

The student assignments for this lesson are:

- Read Student Handouts 1 and 2.

Additional Subject Area Resources

None

Bring to Class

You must bring the following materials to class.

- All reference material.
- Pen or pencil and writing paper.

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Student Handout 2

Extracted Material from AR 600-63

This student handout contains 21 pages of extracted material from AR 600-63, Army Health Promotion:

Topic	Pages
SH-2, Extracted Material from AR 600-63, Army Health Promotion	SH-2-1

Disclaimer: The training developer downloaded this extract from <http://155.217.58.58/atdls.htm>. The text may contain passive voice, misspellings, grammatical errors, etc., and may not be in compliance with the Army Writing Style Program.

RECOVERABLE PUBLICATION

YOU RECEIVED THIS DOCUMENT IN A DAMAGE-FREE CONDITION. DAMAGE, IN ANY WAY, TO INCLUDE HIGHLIGHTING, PENCIL MARKS, OR MISSING PAGES WILL SUBJECT YOU TO PECUNIARY LIABILITY (STATEMENT OF CHARGES, CASH COLLECTION, ETC.) TO RECOVER PRINTING COSTS.

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Army Regulation 600–63

Personnel—General

Army Health Promotion

**Headquarters
Department of the Army
Washington, DC
28 April 1996**

Unclassified

SUMMARY of CHANGE

AR 600-63

Army Health Promotion

this is a new regulation. It --

- o Establishes a health promotion program which integrates many existing programs for Total Army family well being (throughout).
- o Prescribes policies for each health promotion program area (chap 2).
- o Establishes a Health Promotion Council to identify activities, assess effectiveness, prioritize resources, and develop and oversee an installation/community program (chap 3).
- o Provides guidance for controlling smoking in DA controlled spaces, and incorporates the contents of AR 1-8, which is rescinded (chap 4).
- o Establishes the Army Suicide Prevention Program and the Family member Suicide Prevention Program (chap 5).
- o Provides for a Fit To Win Coordinator to plan, initiate, evaluate, and administer the program in coordination with the Health Promotion Council (chap 3).

Change 1 prescribes procedures for a smoke-free workplace for the Department of the Army.

Effective 28 May 1996

Personnel—General

Army Health Promotion



Togo D. West, Jr.
Secretary of the Army

History. This publication was originally printed on 17 November 1987. It was authenticated by Carl E. Vuono, Chief of Staff, and R.L. Dilworth, The Adjutant General. This electronic edition publishes the basic 1987 edition and incorporates Change 1, published on 28 April 1996. Change 1 was authenticated by Togo D. West, Jr., Secretary of the Army.

Summary. This regulation prescribes policy, responsibilities, and procedures for the

Army Health Promotion Program. Change 1 establishes policy and prescribes procedures for a smoke-free workplace for the Department of the Army.

Applicability. This regulation applies to the Active Army, Army National Guard, U.S. Army Reserve, and civilians employed by the Army. The provisions of chapter 4 apply to all visitors, contractors and their personnel, and personnel of other agencies or businesses that operate within or visit Army workplaces.

Proponent and exception authority. Not applicable.

Impact on New Manning System. (Rescinded)

Army management control process. This regulation is not subject to the requirements of AR 11–2. It does not contain internal control provisions.

Supplementation. Supplementation of this regulation is encouraged to tailor health promotion to the local command, but is not required. If supplements are issued, HQDA agencies and major Army commands will furnish one copy of each to HQDA

(DAPE–MPH), WASH DC 20310–0300. Other commands will furnish one copy of each to the next higher headquarters. Policies established in this regulation may not be changed without prior approval of HQDA(DAPE–MPH).

Interim changes. (Rescinded).

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff Personnel, ATTN:DAPE–HR–PR, 300 Army Pentagon, Washington, DC 20310–0300.

Distribution. Distribution of this publication is made in accordance with initial distribution number (IDN) 093611, intended for commands levels A, B, C, D, and E for Active Army, Army National Guard, and U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1

Introduction, page 1

Section I

General, page 1

Purpose • 1–1, page 1

References • 1–2, page 1

Explanation of abbreviations and terms • 1–3, page 1

Objective and scope of the Army Health Promotion Program • 1–4, page 1

Section II

Responsibilities, page 1

Deputy Chief of Staff for Personnel(DCSPER) • 1–5, page 1

Deputy Chief of Staff for Operations and Plans (DCSOPS) • 1–6, page 1

Deputy Chief of Staff for Logistics(DCSLOG) • 1–7, page 1

The Surgeon General (TSG) • 1–8, page 1

The Chief of Public Affairs (CPA) • 1–9, page 1

Chief of Chaplains (CCH) • 1–10, page 1

The Judge Advocate General (TJAG) • 1–11, page 1

Chief of Engineers (COE) • 1–12, page 2

Chief, National Guard Bureau (CNGB) • 1–13, page 2

U.S. Army Reserve (USAR) • 1–14, page 2

Commanding General, U.S. Army Community and Family Support Center (CG, CFSC) • 1–15, page 2

Commanding General, U.S. Army Training and Doctrine Command (CG, TRADOC) • 1–16, page 2

Commanding General, U.S. Army Soldier Support Center (CG, USASSC) • 1–17, page 2

Commanders of major Army commands (MACOMs) • 1–18, page 2

Commanders of U.S. Army installations and military community activities • 1–19, page 2

Medical Department Activity/Medical Center(MEDDAC/MEDCEN) commanders • 1–20, page 2

Commanders at all levels • 1–21, page 2

Chapter 2

Health Promotion Policies, page 2

General • 2–1, page 2

Antitobacco • 2–2, page 3

Physical fitness • 2–3, page 3

Nutrition • 2–4, page 3

Weight control • 2–5, page 3

Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) • 2–6, page 3

Stress management • 2–7, page 4

Suicide prevention • 2–8, page 4

*This regulation supersedes AR 1–8, 18 November 1977.

Contents—Continued

Spiritual fitness • 2-9, *page 4*
Physical examination • 2-10, *page 4*
Hypertension identification • 2-11, *page 4*
Oral health • 2-12, *page 4*
Health risk appraisal • 2-13, *page 5*
Family Fitness Program • 2-14, *page 5*
Acquisition and use of physical fitness and recreation facilities
• 2-15, *page 5*
Army Fit to Win program • 2-16, *page 5*

Chapter 3

Installation Health Promotion Program, *page 5*

Implementation guidance • 3-1, *page 5*
Installation or community Health Promotion Council • 3-2, *page 6*
Development of the installation or community health promotion
program • 3-3, *page 6*
Health promotion process • 3-4, *page 6*
Health risk appraisal administration and command requirements
• 3-5, *page 6*
Unit Climate Profile (UCP) • 3-6, *page 7*

Chapter 4

Controlling Smoking, *page 7*

Guidance for controlling smoking in DA controlled areas • 4-1,
page 7
Policy • 4-2, *page 7*
Signs for controlling smoking • 4-3, *page 8*
Enforcement • 4-4, *page 8*

Chapter 5

Suicide Prevention and Psychological Autopsy, *page 8*

General • 5-1, *page 8*
Army Suicide Prevention Program • 5-2, *page 8*
Suicide Prevention Task Force • 5-3, *page 8*
Coordination of helping services • 5-4, *page 8*
Training • 5-5, *page 8*
Family Member Suicide Prevention Program(FMSPP) • 5-6,
page 9
Reporting and data analysis • 5-7, *page 9*
Psychological autopsy • 5-8, *page 9*

Appendix A. References, *page 10*

Glossary

Chapter 1 Introduction

Section I General

1-1. Purpose

This regulation prescribes policies and responsibilities for the Army Health Promotion Program.

1-2. References

Required and related publications and prescribed forms are listed in appendix A.

1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1-4. Objective and scope of the Army Health Promotion Program

a. The goal of the Army Health Promotion Program is to maximize readiness, combat efficiency, and work performance. Objectives include enhancing the quality of life for all soldiers, Army civilians, family members and retirees; and encouraging lifestyles to improve and protect physical, emotional, and spiritual health.

b. The Army Health Promotion Program encompasses a variety of activities designed to facilitate behavioral and environmental alterations to improve or protect health. This includes a combination of health education and related organizational, social, emotional, spiritual, and health care activities and initiatives. These are integrated to produce a single, comprehensive program.

c. Functionally, the components of health promotion consist of all activities for members of the Total Army Family in the following areas:

- (1) Antitobacco.
- (2) Physical conditioning.
- (3) Weight control.
- (4) Nutrition.
- (5) Stress management.
- (6) Alcohol and drug abuse prevention and control.
- (7) Early identification of hypertension.
- (8) Suicide prevention.
- (9) Spiritual fitness.
- (10) Oral health.

d. In addition to the components listed above, health promotion necessarily includes other related activities. These include such things as physical and dental examinations, health risk appraisals, physical fitness facilities, recreation and leisure education and activities, as well as initiatives to promote social and emotional well-being. These activities are coordinated and integrated into a comprehensive Army Health Promotion Program called "Fit To Win."

e. Operationally, health promotion is implemented and enhanced at the installation level through a health promotion program as provided in this regulation.

Section II Responsibilities

1-5. Deputy Chief of Staff for Personnel(DCSPER)

The DCSPER is the Army Staff proponent for the following:

- a. The Army Health Promotion Program and implementing DOD Directive 1010.10.
- b. The Alcohol and Drug Abuse Prevention and Control Program(ADAPCP).
- c. Antitobacco program.
- d. Army Weight Control Program.
- e. Suicide prevention to include coordination and monitoring of the Army Suicide Prevention Program (ASPP).

1-6. Deputy Chief of Staff for Operations and Plans (DCSOPS)

The DCSOPS has Army Staff responsibility for the Army Physical Fitness Program (APFP).

1-7. Deputy Chief of Staff for Logistics(DCSLOG)

The DCSLOG is the proponent for development and implementation of policies and programs concerning nutrition in troop dining facilities and commissaries.

1-8. The Surgeon General (TSG)

TSG—

a. Develops policy for all medical, dental, psychological, physiological, and health areas including diet, weight and body fat standards, cardiovascular risk factor reduction, nutrition, and stress management, and assists in policy development in other areas including Army health promotion, physical fitness and exercise, control of substance abuse, suicide prevention, and antitobacco use.

b. Has Army Staff responsibility for stress management.

c. Acts as Department of Defense executive agent for nutrition(to include Army Staff responsibility) for policy, standards, and education programs.

d. Is the Army Staff proponent for early identification of hypertension.

e. Is the Army Staff proponent for oral health promotion.

f. Appoints a representative with an appropriate health care background to serve along with the representative from ODCSPER as a member of the DOD Health Promotion Coordinating Committee.

g. Plans, implements, and evaluates an automated health risk appraisal with procedures for administration and for processing and compiling the data at HQDA, MACOM, installation or community, and unit levels.

h. Advises the DCSPER with respect to all medical and psychiatric aspects of health promotion to include the epidemiological aspects of suicide.

i. Oversees the technical aspects of Army training programs in suicide prevention.

j. Assures that Army Medical Departments (AMEDDs)provide—

(1) Equipment and health care providers to administer and interpret the health risk appraisal, teach classes, and compile statistics to support the health promotion program.

(2) Training for health care providers in suicide risk identification and treatment for patients who may be at increased risk of suicide.

1-9. The Chief of Public Affairs (CPA)

The CPA is responsible for the development and implementation of a public affairs plan in support of the Army Health Promotion Program. This includes articles in internal print and broadcast media, and release of information about the Army Health Promotion Program to the public through the media and through community relations.

1-10. Chief of Chaplains (CCH)

The CCH—

a. Has Army special staff responsibility for the installation chaplain family life center program, spiritual fitness, and battle fatigue ministry.

b. Encourages and promotes concepts of spiritual well-being and good health among soldiers and family members.

c. Coordinates suicide prevention activities with the DCSPER and TSG.

1-11. The Judge Advocate General (TJAG)

TJAG—

a. Provides staff assistance and advice for the interpretation of appropriate laws and concerning regulations the Army Health Promotion Program.

b. Reviews the liability implications of nonhealth professionals providing health promotion programs.

1-12. Chief of Engineers (COE)

The COE has Army special staff responsibility for the construction of installation physical fitness and recreation facilities supported by appropriated funds.

1-13. Chief, National Guard Bureau (CNGB)

The CNGB prescribes policy and programs for health promotion within the Army National Guard (ARNG), and encourages State adjutants general to develop health promotion programs including suicide prevention and oral health.

1-14. U.S. Army Reserve (USAR)

Responsibilities for administering the health promotion program, to include suicide prevention, in the USAR are as follows:

- a. The Chief, Army Reserve (CAR) The CAR, in coordination with the Deputy Chief of Staff for Personnel, prescribes policy and monitors health promotion for the USAR.
- b. The Commanding General, U.S. Forces Command (CG, FORSCOM), executes health promotion policy and procedures for USAR troop program units (TPUs) in the Continental United States (CONUS).
- c. The Commanding General, U.S. Army Western Command (CG, WESTCOM) executes health promotion policy and procedures for all assigned USAR TPUs and activities in Hawaii and in possessions, trusts, and territories administered by the United States in the Pacific Command Area.
- d. The Commander-in-Chief, U.S. Army Europe (CINUSAREUR) and Seventh Army executes health promotion policy and procedures for all assigned USAR TPUs in Europe.
- e. The Commanding General, U.S. Army Reserve Personnel Center (CG, ARPERCEN), is the administrator of health promotion policy and procedures for the Individual Ready Reserve (IRR).

1-15. Commanding General, U.S. Army Community and Family Support Center (CG, CFSC)

The CG, CFSC—

- a. Appoints the CFSC Family Fitness Coordinator to serve as an adviser to the Army Health Promotion Council.
- b. Has Army operational responsibility for installation physical fitness and recreation facilities supported by nonappropriated funds (NAF).
- c. Has special staff responsibility for Total Army family recreation programs.
- d. Defines the role and trains Army Community Service (ACS) personnel in support of suicide risk identification efforts using technical assistance from mental health officers.
- e. Develops suicide prevention education and community awareness programs for family members.

1-16. Commanding General, U.S. Army Training and Doctrine Command (CG, TRADOC)

The CG, TRADOC—

- a. Coordinates the inclusion of Army health promotion into Army school curricula.
- b. Develops training support packages for suicide risk identification for unit leaders.
- c. Provides suicide risk identification training for leadership courses.
- d. Implements Army policy to control use of tobacco products during initial entry training.

1-17. Commanding General, U.S. Army Soldier Support Center (CG, USASSC)

The CG, USASSC, is responsible for Army physical fitness doctrine.

1-18. Commanders of major Army commands (MACOMs)

All MACOM commanders will—

- a. Monitor data, and develop and implement programs to achieve Army health promotion.
- b. Appoint a Fit To Win Coordinator to provide staff supervision

for the implementation of actions and procedures of this regulation and its relationship to all members of the Total Army Family.

- c. Appoint a Suicide Prevention Coordinator to provide installation assistance for and staff supervision of the ASPP.
- d. Develop and implement a MACOM Suicide Prevention Plan.

1-19. Commanders of U.S. Army installations and military community activities

These commanders will—

- a. Establish and chair a Health Promotion Council.
- b. Appoint a Fit To Win Coordinator to integrate health promotion activities and monitor program progress at their installations.
- c. Monitor aggregate data and implement a health promotion program at their installations in accordance with this regulation and instructions from their MACOM commanders.
- d. Appoint a task force or committee and designate a presiding officer to plan, implement, and manage the ASPP.
- e. Coordinate with union organizations representing civilians employed by the Army as applicable.

1-20. Medical Department Activity/Medical Center (MEDDAC/MEDCEN) commanders

These commanders will—

- a. Serve with Directors of Personnel and Community Activities (DPCAs) as principal advisers to the installation/community commander with respect to Army health promotion.
- b. Provide equipment and health care providers to administer and interpret the health risk appraisal, teach classes, and compile statistics to support the health promotion program.
- c. Integrate activities formerly planned and coordinated by the Community Health Education Program (CHEP) and the Health Initiatives Fitness Team (HIFIT) into the installation or community Health Promotion Council; and use ad hoc or subcommittees to address specific issues involving health promotion in the MTFs.
- d. Develop protocols for the identification and management of suicidal patients in each patient care unit of the medical treatment facility (MTF) and provide inservice suicide prevention training for health care providers.
- e. Provide a mental health officer to conduct a psychological autopsy when required by this regulation.
- f. Provide advice and assistance to commanders of RC units in order to facilitate and implement health promotion policies.

1-21. Commanders at all levels

These commanders will—

- a. Remain sensitive and responsive to the needs of soldiers, Army civilians, family members, and retirees.
- b. Encourage soldiers, Army civilians, and family members to practice a lifestyle that improves and protects physical, emotional, and spiritual well-being.
- c. Enhance unit readiness and maximize human resources by implementing the Fit To Win program within their units.
- d. Initiate proactive measures to prevent loss of life within their unit due to suicide and to reduce the impact on survivors if a suicide takes place.
- e. Demonstrate positive efforts to deglamorize the use of all forms of tobacco products.
- f. Enhance unit readiness and maximize human resources by referring soldiers in Dental Fitness Classes 3 and 4 for examination and treatment to attain at least Dental Fitness Class 2. (See para 2-12.)
- g. Ensure that all soldiers and family members understand the availability of dental care at post facilities and the use of the dental insurance plan for treatment at civilian facilities.

Chapter 2 Health Promotion Policies

2-1. General

a. Health promotion policies apply to all Total Army activities and operating agencies. Active participation in all aspects of health promotion will be encouraged.

b. Health promotion increases unit readiness and combat and organizational efficiency by maximizing human resources. These activities encompass physical, emotional, spiritual, and social dimensions. They are positive actions and health education whose total effect improves unit and organizational performance by enhancing individual well-being.

2-2. Antitobacco

a. The use of all forms of tobacco products during initial entry training is controlled for soldiers. (See chap 4.)

b. Commanders and supervisors will encourage family members and retirees to engage in appropriate antitobacco activities.

c. As part of routine physical and dental examinations and at other appropriate times, such as prenatal and well baby clinics, health care providers will inquire about the patient's tobacco use, including use of smokeless tobacco products, and advise them of risks associated with use, the health benefits of abstinence, and where to obtain help to quit.

d. Army policy on smoking in the workplace is in chapter 4.

2-3. Physical fitness

Physical fitness includes factors that allow people to function effectively in physical or mental work and in training or recreation, and still have energy to handle emergencies. This includes cardiorespiratory fitness, muscular strength and endurance, flexibility, and body composition. (See AR 215-2, AR 350-15, DA Pam 350-18, and DA Pam 350-21 for specific information.)

a. Soldiers

(1) Commanders and supervisors will establish and conduct physical fitness programs for soldiers consistent with AR 350-15, FM 21-20, and the unit mission. Exercise periods are to be conducted with sufficient intensity, frequency, and duration to maintain adequate cardiorespiratory endurance, muscular strength and endurance, and flexibility.

(2) All soldiers in the Active Component (AC) and the Reserve Component (RC) are expected to take part in either collective or individual physical fitness training programs year-round.

(3) AC and RC soldiers, age 40 and over, are required to complete medical screening as prescribed in AR 40-501 and AR 350-15 in a timely manner and as close to their 40th birthday as possible. Once cleared, they will participate fully in unit or individual programs and testing in accordance with AR 350-15.

b. Civilians employed by the Army.

(1) Civilians employed by the Army are encouraged to engage in a regular program of exercise and other positive health habits.

(2) For employees engaged in an occupation that requires physical strength and stamina for satisfactory performance (for example, firefighter), a physical exercise program may be a part of their jobs and may be conducted during duty hours.

(3) For other employees, commanders may approve up to 3 hours administrative leave per week to allow employees to participate in command sponsored physical exercise training, monitoring, and/or education, provided these activities are an integral part of a total fitness program and are time-limited, that is, 6 to 8 weeks in duration.

(4) While formal physical fitness programs may be repeated from time-to-time, employees will not be given administrative leave for physical exercise training once they have already received such training. This grant is limited to one time only. It does not apply to other types of training or professional development. (See AR 690-400.)

(5) Beyond these situations, work schedules should be adjusted to

permit training and exercise where possible and where consistent with workload and mission.

2-4. Nutrition

a. Dietary allowances prescribed in AR 40-25 provide guidelines and standards for feeding healthy soldiers. They are intended for use by personnel involved in menu planning, dietary evaluation, nutrition education and research, and food research and development.

b. Nutrient standards for operational rations establish the criteria for evaluating the nutritional adequacy of these rations. Operational rations are composed of nonperishable foods. They are designed to provide complete nutrition for the soldier in simulated or actual combat conditions.

c. Basic guidelines for nutrition education are used to promote optimal fitness in the military population. They guide modification in food procurement policy, food preparation, recipe formulation, and menu development.

d. Installation commanders, dietitians, food advisers, nutritionists, and food service noncommissioned officers (NCOs) will comply with the basic nutritional standards for garrison dining facilities in AR 30-1, appendix J. This appendix provides implementing guidance for meeting nutrition standards in garrison dining facilities and ensuring compliance with AR 40-25.

e. Commanders will ensure that nutrition information, education, and counseling programs are provided to soldiers, family members, Army civilians, and food outlet managers in activities under their control. These programs are provided by, or coordinated with, qualified health care professionals.

2-5. Weight control

a. Commanders and supervisors will monitor all soldiers in their commands in accordance with AR 600-9 to ensure they maintain proper body weight, body composition, and personal appearance standards. At a minimum, AC and RC soldiers will be weighed when they take the APFT or for AC soldiers at least every 6 months.

b. Commanders and supervisors will provide educational and other motivational programs in accordance with AR 600-9 in order to encourage persons to attain and maintain proper body fat standards. Army civilians, family members, and retirees should be included in these programs.

c. Soldiers exceeding body fat standards are subject to the restrictions established in AR 600-9.

2-6. Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)

The ADAPCP includes all activities to eliminate substance abuse, including prevention, identification, education, and rehabilitation services. It includes residential and nonresidential treatment. (See AR 600-85.)

a. Alcohol and drug abuse is incompatible with military service. Soldiers identified as alcohol or drug abusers who, if in the opinion of their commanders, warrant retention, will be afforded the opportunity for rehabilitation in accordance with AR 600-85. Soldiers identified as alcohol abusers who do not warrant retention are to be considered for separation. Consideration and processing for separation for soldiers identified as drug abusers will be in accordance with AR 600-85 and applicable administrative regulations.

b. All levels of the chain of command must take prompt action, regardless of rank or grade, if alcohol or other drug abuse is suspected.

c. Implementation of an ADAPCP capability is required for installations, communities, and activities in accordance with AR 600-85.

d. Installation, community, and activity commanders will ensure that an active and aggressive drug testing program is maintained.

e. Alcohol and drug abuse policy will be given adequate publicity to ensure that eligible civilians, family members, and retirees are aware of—

(1) Command support.

(2) Available information.

(3) Referral procedures.

(4) Rehabilitation services of ADAPCP.

f. Enrollment of Army civilians, family members, and retirees is voluntary. The commander of the servicing installation or activity is responsible for developing procedures by which Army civilians may use ADAPCP facilities and services.

g. Commanders, supervisors, and hospitality, recreation, and health care providers will provide education for all members of the Total Army family on the detrimental effects of alcohol and drug abuse on combat readiness and a healthy lifestyle.

2-7. Stress management

Stress management includes all assistance provided to cope with the demands, real or perceived, from the environment, and from within the individual.

a. Stress, its effects, and its management, is a concern for leaders at every level. Techniques and considerations for the management of stress in Army operations are in FM 26-2.

b. Health care providers and unit ministry team (UMT) personnel assist commanders in the development and implementation of a comprehensive stress prevention effort to increase the ability of individual soldiers and Army civilians to positively deal with stress.

c. Health care providers implement health education and treatment programs for individuals affected by stress. Protocols for referring soldiers, family members, and Army civilians to other agencies will agree with established procedures.

d. Health care providers conduct training programs designed to alert health care providers, commanders, and supervisors regarding evidence of stress affecting an individual.

e. Community recreation professionals will develop and execute leisure activities designed to enhance self-esteem and provide outlets for tension and stress-related energies.

f. The stress of active combat operations often leads to a combat stress reaction called battle fatigue. Commanders, staff officers, and proponent agencies should be aware how—

(1) Unit ministry teams provide preventive, immediate, and replenishing spiritual and emotional support and care to soldiers experiencing battle fatigue.

(2) Combat stress teams trauma implement the medical recovery aspects of battle fatigue.

2-8. Suicide prevention

a. Suicide prevention is the concern of every leader, commander, supervisor, soldier, and Army civilian.

b. A coordinated program for suicide prevention will be established at every Army installation, community, and activity in accordance with the policies set forth in chapter 5.

2-9. Spiritual fitness

A spiritually fit person recognizes there are multiple dimensions that make up the human being. He or she seeks to develop the total person concept. This includes enhancing spiritual fitness through reflection and practice of a lifestyle based on personal qualities needed to sustain a person in times of stress, hardship, and tragedy. When a person's actions are different from his or her stated values, the person lives with inner conflict. This person struggles for integrity and congruity, but cannot find inner peace until this struggle is dealt with. The extent to which this is accomplished is a measure of spiritual fitness.

a. Commanders at all levels shall encourage and provide for human self-development activities leading to increased spiritual fitness in accordance with this regulation, AR 600-20, AR 165-20, and other applicable directives.

b. Army leaders should develop an awareness of the lifestyles, cultural backgrounds, stages of development, possible relationships to religious beliefs, and needs of soldiers, Army civilians, and family members. HPCs will recommend, coordinate, and ensure the integration of spiritual fitness programs for units, soldiers, family members, and Army civilians in their area of responsibility.

c. Commanders at the installation and community level shall

develop soldier and family support activities to undergird, reinforce, and implement the enhancement of spiritual fitness. They will ensure the scheduling of time for activities, programs, and training to accomplish the goals of spiritual fitness, as well as recommending and conducting spiritual fitness programs.

d. In providing for self-development activities, commanders and other leaders must ensure advocacy of a religion does not occur. The practice of religion, to the extent it relates to spiritual fitness, must be left to the sole discretion of the individual soldier, family member, or Army civilian. They must be free to worship or not as he or she may choose without fear of being disciplined or stigmatized by his or her choice. (See AR 165-20, AR 600-20 and DA Pam 600-75.)

e. All soldiers and Army civilians are expected to live by the tenets of the professional Army ethic and those individual values that support and sustain the Army way of life. (See FM 100-1.)

2-10. Physical examination

a. Health care providers will conduct physical examinations and a health risk appraisal in accordance with the procedures of AR 40-501 and separate directives.

b. All soldiers age 40 and over will be screened for cardiovascular risk as well as other limiting factors as part of their periodic physical examinations and in accordance with AR 40-501.

2-11. Hypertension identification

a. The early identification of hypertension includes all initiatives to identify those with a positive family history, and to identify and treat the following health risk factors:

- (1) High blood pressure
- (2) Tobacco use
- (3) Elevated cholesterol level
- (4) Obesity
- (5) Poor nutrition
- (6) Inactivity
- (7) Stress
- (8) Alcohol and drug abuse

b. These initiatives include early identification, information regarding control and lifestyle factors, and treatment referral. Health care providers will—

(1) Inform soldiers during the periodic physical examination about the effects on hypertension of cholesterol, weight, blood pressure, family history, and lifestyle habits.

(2) Develop and implement protocols for referring individuals with significant health risk factors.

(3) Conduct a cardiovascular screening program for soldiers age 40 and over as prescribed in AR 40-501 and separate directives.

(4) Provide basic information materials on hypertension suitable for use by commanders, supervisors, or counselors outside the health care setting.

(5) Develop and implement procedures to provide annual blood pressure measurement for soldiers and selected family members. As a minimum, hypertension screening is provided as part of all medical examinations, health risk appraisals, and the annual dental examinations for members of the Total Army family. Screening is also provided to other beneficiaries, including those in the Children's Preventive Dentistry Program at the time of their original request for care. Patients with abnormal screening results will receive appropriate medical referrals.

2-12. Oral health

a. Oral health promotion includes all initiatives to increase the overall fitness and dental readiness of soldiers, reduce the incidence of dental disease in the community, identify community members in need of dental treatment, and direct them to sources of appropriate care. It expands the traditional dental program by—

(1) Requiring a minimum level of dental health for active duty soldiers.

(2) Providing to the community information concerning the dental insurance program for family member dental care.

(3) Using the HRA questionnaire dental data as a tool to help evaluate community oral health.

(4) Integrating hypertension screening and tobacco use counseling into the dental examinations and treatment plans.

b. This program includes all traditional preventive dentistry activities described in AR 40–35.

(1) *Oral Health Fitness Program.* The Oral Health Fitness Program is designed to ensure that soldiers maintain optimum oral health and do not lose valuable personal or unit time due to preventable dental disease. Each active duty soldier is required to receive an annual dental examination. Results of the examination are used to establish a Dental Fitness Classification which is monitored by the soldier's unit through the installation automated personnel data base. Commanders will ensure that soldiers receive examinations and required treatment to maintain at least a Dental Fitness Class 2. A brief description of the classifications follows. The complete description is found in AR 40–35.

(a) Dental Fitness Class 1: Requires no dental treatment.

(b) Dental Fitness Class 2: Unlikely to have a dental emergency within 12 months.

(c) Dental Fitness Class 3: Likely to have a dental emergency within 12 months.

(d) Dental Fitness Class 4: Needs a dental examination, or status is unknown.

(2) *Preventive Dentistry Program for children.* This program allows DENTACS to provide, on a space available basis, an oral screening examination, instructions on hygiene procedures, and topical application of anticariogenic agents. Sports mouthguards and pit and fissure sealants may be provided as appropriate.

(3) *Clinical Preventive Dentistry Program.* Clinical preventive measures are included in this program and include all plaque control technique instruction and evaluation, oral prophylaxis, and nutritional counseling as appropriate.

(4) *Community Preventive Dentistry Program.* Community education programs and fluoridation of community water supplies and/or alternative fluoride administration procedures are prescribed under this program. Also included are programs for reporting child neglect or abuse to the local Family Advocacy Program.

2–13. Health risk appraisal

a. Individuals will be aware of their health risk profile and of ways to improve their lifestyles to reduce health risks.

b. Health care providers will use the approved health risk appraisal instrument in accordance with applicable regulations and directives to screen soldiers, family members, Army civilians, and retirees for health risk factors. The results of this appraisal will be given to the individual as a health risk appraisal profile.

c. Enlistees will be administered a health risk appraisal in the reception battalion upon entry into the Army. IET trainees will be given a health risk appraisal profile either in basic training, advanced individual training (AIT), or one-station unit training (OSUT). Officers will be administered a health risk appraisal during the officer basic course (OBC).

d. All soldiers will receive a health risk appraisal as part of the ongoing periodic physical examination (for example, 5-year, over-40 screen, or flight physical). The health appraisal profile is the responsibility of the administering MTF commander.

e. Commanders will ensure—

(1) During PCS inprocessing that soldiers receive a health risk appraisal unless their current health risk appraisal occurred within the last 12 months.

(2) During regular records screening that soldiers have a current (not more than three years old) health risk appraisal.

(3) A program of education and consultation is available to meet identified needs.

(4) Soldiers understand their health risk appraisal profile and the command actions that can be taken to manage health risks.

2–14. Family Fitness Program

a. Existing Army fitness programs that promote well-being will

include family members. A total program of family fitness supports—

(1) Readiness

(2) Leadership

(3) Quality of life

(4) Sustainment

(5) Personnel functions

b. This program will promote all aspects of Army Health Promotion addressed by this regulation. (See AR 215–2 and DA Pam 350–21.)

2–15. Acquisition and use of physical fitness and recreation facilities

a. Commanders may use appropriated funds to obtain service contracts to provide physical fitness facilities for soldiers and Army civilians through routine procurement channels. When physical fitness facilities exist in a building that has been leased for use by DA agencies, it is appropriate for the lease to be amended to provide access to these facilities for soldiers and Army civilians. Specific procedures and policies concerning the use of appropriated funds for such acquisition are in purchasing and contracting regulations and guidelines, and in AR 215–2, paragraph 6–4.

b. Army civilians who are not subject to mandatory physical fitness standards may use physical fitness and other recreation facilities to the maximum extent possible consistent with AR 215–2.

c. As an inherent responsibility of command, commanders may establish the priority between soldiers, Army civilians, and family members for the use of physical fitness facilities, consistent with resource availability, mission, and training requirements. Policies discussed in this paragraph apply to those minimally essential facilities whose primary purpose is physical fitness. They do not apply to those designed principally for community recreation activities such as bowling alleys, golf courses, and tennis courts. AR 215–2 permits Army civilians to use community recreation facilities on a space available basis at no cost to the Government.

2–16. Army Fit to Win program

a. The Army Fit to Win program provides the means to begin integrated and coordinated implementation of the health promotion program at the installation level. When fully implemented, such an activity should allow commanders to—

(1) Actively market all aspects of the installation program.

(2) Conduct community needs assessments in health promotion areas.

(3) Provide a program of education and consultation to meet identified needs.

(4) Sustain program participation.

(5) Support Army-wide data collection for program evaluation.

b. DA Pam 600–63 (1–13) details operations and education.

Chapter 3 Installation Health Promotion Program

3–1. Implementation guidance

a. The success of the Army Health Promotion Program is determined by the effectiveness of the efforts of installation and community commanders. An effective, comprehensive program at the installation and community level is the key to achieving the overall goals.

b. Installation and community health promotion programs must focus on initiatives and activities to enhance individual health in each of the major areas of the program.

c. The operational pamphlets for implementing the program are contained in the Army's Fit To Win program. (See DA Pam 600–63).

d. Installation or community health promotion programs should contain the following key elements:

(1) Health education to raise individual awareness of all aspects of the program.

(2) Lifestyle assessment to identify individuals who could benefit from program participation.

(3) Counseling programs to reduce risk factors.

(4) Counseling programs to motivate and help sustain a healthy lifestyle for all.

(5) Proactive programs to foster suicide prevention and increase spiritual fitness.

(6) A program directed at the total population (soldiers, family members, retirees, and Army civilians).

(7) A means to allow commanders to monitor program effectiveness.

3-2. Installation or community Health Promotion Council

a. The installation or community commander administers and controls the health promotion program through the Health Promotion Council (HPC) and the Fit To Win Coordinator. These are the commander's primary advisers. The presiding officer of the HPC is the commander or his or her designated representative from the command group. The Family Fitness Coordinator prescribed in AR 215-2 may be used, if qualified, to be the installation or community Fit To Win Coordinator.

b. The membership encompasses the full scale of health and fitness interests on the installation—

(1) Deputy for Personnel and Community Activities (DPCA)

(2) Commander, Medical Treatment Facility (MTF)

(3) Director of Logistics (DOL)

(4) Director for Plans, Training, and Mobilization (DPTM)

(5) Commander, Dental Activity/Director of Dental Services

(6) Staff Chaplain

(7) Fit To Win Coordinator

(8) Civilian personnel officer (CPO)

(9) Public affairs officer (PAO)

(10) Chief, Community Mental Health Service (CMHS)

(11) Community health nurse

(12) Safety officer

(13) Chief, Family Support Division (FSD)

(14) Chief, Community Recreation Division (CRD)

(15) Chief, Community Operations Division (COD)

(16) Post librarian

(17) Family Fitness Coordinator

(18) Alcohol and Drug Abuse Control Program Officer

(19) Post Food Adviser

(20) MTF Dietitian/Division nutritionist

(21) Field Director, American Red Cross (ARC)

(22) Tenant unit commanders

(23) Master fitness trainer

(24) MTF Fitness Facilitator

(25) Reserve Component advisers

(26) Others as desired

c. Principal tasks of each installation or community HPC are to—

(1) Identify existing health promotion programs.

(2) Integrate MTF programs with other post health promotion programs.

(3) Assess the strengths and weaknesses of programs.

(4) Identify and assess other existing resources.

(5) Assess community needs.

(6) Develop a plan for a health promotion program based on the health and fitness needs for the Total Army family.

(7) Develop a comprehensive marketing plan based on existing resources, demographics, and identified fitness needs.

3-3. Development of the installation or community health promotion program

a. The installation or community commander develops and implements the health promotion program. Key stages are shown in figure 3-1.

b. Once community or installation needs are identified, specific program elements to address each of the major health promotion areas must be initiated. These include classes, seminars, workshops,

and activities in each of the Fit To Win program areas. Existing programs may be used to meet these needs.

c. Commanders will ensure the goals, objectives, and purposes of the health promotion program are well-publicized throughout the command. Such efforts should keep soldiers, Army civilians, family members, and retirees aware of program benefits. This includes the relationship and interaction among members of the overall program and its component parts.

d. These initiatives, facilitated by the Fit to Win Coordinator using all the resources of the HPC, will ensure the effectiveness of the overall program and should ensure participation by all elements of the command.

e. Screening and assessment of individuals are primarily accomplished by using a health risk appraisal to assess the current state of health and fitness. This is an automated, personalized instrument, asking the participant about family health history, lifestyle, and attitudes. Other data, such as height, weight, blood pressure, and cholesterol level are also used.

f. Assessment begins during IET and OBC. It is continued during periodic physical examinations, PCS inprocessing, by referral, or is unit initiated. Self-referral is the principal means of accessing family members, Army civilians, and retirees.

g. The data enter the installation or community data base, are compiled, and used by the Fit To Win Coordinator, HPCs, and commanders to allocate resources, revise programs, and monitor progress and unit well-being.

h. Individual data from the health risk appraisal are compared, where possible, against predetermined standards. If standards are met, no intervention or education is required. Interim referrals may be initiated by the commander or health care providers prior to the next scheduled health risk appraisal.

i. A health risk appraisal profile, compiled and printed using an automated process, is given to the individual. Profile data are also placed in the person's MTF medical record or given to the person if a record is not maintained.

j. If follow-up based on identified individual or unit needs is required, the intervention and education stage begins and strategies are targeted. Purely medical interventions are referred to the MTF for soldiers, family members, and retirees, and to private physicians for Army civilians.

k. Reevaluation occurs with the next scheduled health risk appraisal.

l. Figure 3-2 portrays the health risk appraisal process in all its stages.

3-4. Health promotion process

a. The health promotion process described in paragraph 3-3 encompasses actions that will—

(1) Bring people into the program.

(2) Gather the necessary data.

(3) Enter data into a computer program and data base.

(4) Measure data against Army standards.

(5) Educate and intervene for individual and unit well-being.

(6) Reevaluate the program.

b. Army health promotion emphasizes positive action to increase physical, emotional, and spiritual well-being.

3-5. Health risk appraisal administration and command requirements

a. Administering the health risk appraisal at installation/community and unit level involves the individual, the commander, health care providers, and other resources available within the command. Their interaction is monitored by the HPC.

b. The laboratory analysis of the health risk appraisal is done by drawing blood.

c. Blood pressure, height, weight, and heart rate are measured and entered on health risk appraisal instrument.

d. After completion of the health risk appraisal questionnaire, all data are entered into the computer. An individual health risk appraisal profile is printed. One copy is given to each individual and

one is placed into medical records maintained by the MTF. Supporting personnel service centers (PSCs) and unit personnel NCOs are provided a by-name roster of those who have taken a health risk appraisal. Unit commanders will ensure all personnel in their command are evaluated.

e. Unit health care providers will monitor unit soldiers recommended for or enrolled in health education programs, and advise the commander on the state of unit well-being.

f. Aggregate data are also compiled by health care providers using the individual data. Quarterly reports allow commanders and the HPC to—

(1) Monitor program status, progress of fitness initiatives, and overall installation, community, and unit well-being.

(2) Ensure appropriate health promotion programs are initiated.

(3) Manage resources necessary to support the program.

3-6. Unit Climate Profile (UCP)

a. Unit “climate” factors such as cohesiveness, morale, and attitude have a profound impact on the effectiveness and efficiency of a unit. DA Pam 600-69 provides a way for company-level commanders to identify unit strengths and weaknesses associated with unit climate factors. An easy-to-use UCP questionnaire and its resulting profile provide information on—

(1) Officer leadership.

(2) NCO leadership.

(3) Immediate leaders.

(4) Leader accessibility.

(5) Promotion policy.

(6) Rewards and corrective actions.

(7) Quality of training.

(8) Tools, equipment, and supplies.

(9) Job satisfaction.

(10) Freedom from harassment.

(11) Military courtesy and discipline.

(12) Human relations.

(13) Unit cohesiveness.

(14) Athletic and nonathletic recreational activities.

(15) Social activities.

(16) Freedom from substance abuse.

(17) Food service and soldier eating habits.

(18) Soldier attitude toward unit.

(19) Morale.

(20) Reenlistment potential.

b. The UCP requires no specific training to administer or analyze.

Chapter 4 Controlling Smoking

4-1. Guidance for controlling smoking in DA controlled areas

a. Smoking tobacco harms readiness by impairing physical fitness and by increasing illness, absenteeism, premature death, and health care costs. Readiness will be enhanced by establishing the standard of a smoke-free environment that supports abstinence from and discourages use of tobacco.

b. Full cooperation of all commanders, supervisors, soldiers, and Army civilians is expected to ensure people are protected from the effects of secondhand smoke.

c. All organizational elements (Active, Reserve, appropriated and non-appropriated civilian personnel) that occupy space in or on conveyances, offices, buildings, or facilities over which DA has custody and control will comply with Army policy and guidance. This includes space assigned to the Army by General Services Administration (GSA) or space contracted from other sources.

d. This policy does not cancel or supersede other instructions that

control smoking because of fire, explosion, or other safety considerations.

4-2. Policy

Smoking of tobacco products is prohibited in all DA-occupied workplaces, with the exception of recreation facilities discussed below. The workplace includes any are inside a building or facility over which DA has custody and control where work is performed by military personnel, civilians, or persons under contract to the Army.

a. Notices will be displayed at entrances to buildings and facilities over which DA has custody and control which state that smoking is not allowed except in designated outdoor smoking areas. Indoor designated smoking areas are prohibited.

b. If possible, designated outdoor smoking areas will provide a reasonable measure of protection from the elements. However, the designated areas will be at least 50 feet from common points of ingress/egress and will not be located in areas that are commonly used by nonsmokers.

c. Smoking of tobacco products is prohibited in all military vehicles and aircraft and all official vans and buses.

d. Smoking is permitted in individually assigned family and unaccompanied personnel living quarters as long as the quarters do not share a common heating/ventilation/air conditioning (HVAC) system. Smoking will only be allowed in quarters with common HVAC systems if an air quality survey can establish that the indoor air quality protects nonsmokers from environmental tobacco smoke (ETS). The American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) has established that 20 cubic feet per minute per person of outside fresh air is required. The carbon dioxide (CO₂) level should not exceed 1000 parts per million (PPM). When individual living quarters are not required or are not available, and two or more individuals are assigned to one room, smoking and nonsmoking preferences will be a determinate factor during the assignment of rooms. The installation commander will provide affirmative procedures to reassign nonsmokers to living space not also occupied by a smoker; and, if necessary, reassign smokers to living space where they may smoke.

e. Smoking is not permitted in common spaces of multiple housing areas such as family housing apartments, unaccompanied personnel housing, transient housing, and Army-operated hotels. Common space is defined as any space within a building that is common to occupants and visitors. These areas include, but are not limited to, corridors, laundry rooms, lounges, stairways, elevators, lobbies, storage areas, and restrooms.

f. Health care providers will not smoke in the presence of patients.

g. Smoking by students is prohibited on the grounds of DOD Dependent Schools (DODDS), Section 6, or other schools over which DA exercises control, except as provided for by the Director, DODDS. Visiting adults, faculty, and staff may smoke out of the presence or view of students in smoking areas designated in accordance with this policy.

h. Smoking is prohibited in all child development centers and youth activity facilities, except that visiting adults and staff may smoke out of the presence or view of children in smoking areas designated in accordance with this policy.

i. Smoking is prohibited where it presents a safety hazard, for example, firing ranges, ammunition storage areas, fuel dumps, motor pools, and equipment maintenance shops.

j. Smoking during basic combat or one-station unit training is prohibited. Smoking during advanced individual training or officer basic courses is controlled and limited to designated times and places during the training day. Cadre and faculty of any military school will not use tobacco products in the presence or view of students while on duty. Commandants will evaluate their policies and practices to eliminate conflicting messages on tobacco.

k. Health education classes regarding the use of tobacco products and its related health problems will be provided throughout professional military training. Classes will be offered during basic and

advanced courses for enlisted and officer (warrant and commissioned) soldiers.

l. Installation commanders will determine whether or not to allow designated smoking areas within recreational areas such as bowling areas, golf courses, clubs, recreation centers, and so forth. If a commander chooses to designate smoking areas, the policies prescribed will not be more permissive than the smoking policies established by state and local governments for similar commercial/private operated establishments.

m. Hotel facilities operated or owned by the Army will designate at least 50 percent of the rooms "nonsmoking." Patrons will be asked if they desire a smoking or nonsmoking room. Every effort will be made to provide nonsmokers with rooms that have not previously been rented to smokers.

n. Smokers will not be allowed additional time beyond routine breaks to be away from their jobs for smoke breaks. Supervisors will monitor their workers and initiate appropriate administrative action if workers are noncompliant with applicable regulations and negotiated agreements.

o. Installations will provide smoking cessation programs for all health care beneficiaries. If not available through military medical treatment facilities, commanders will coordinate programs through local community resources such as the American Cancer Society and American Lung Association. To the extent possible, occupational health clinics will provide smoking cessation programs for civilian employees. If such programs are not feasible at a particular installation, the occupational health clinic will refer civilian employees seeking such a program to local community resources.

p. If conditions of employment of bargaining unit members are affected by this policy, installation, commanders will begin negotiations as soon as practical with unions. (Changes in smoking policies that impact on bargaining unit members affect their conditions of employment.) Management is obligated to bargain over changes in conditions of employment before implementing this regulation as to civilian bargaining unit members.

4-3. Signs for controlling smoking

a. Commanders are authorized to continue to use locally manufactured signs already reproduced or posted.

b. If locally manufactured signs are not in use, DA Form 5560-R (No Smoking Except in Designated Smoking Areas) and DA Form 5560-1-R (Designated Smoking Area) will be used for restricting smoking. These will be locally reproduced on 8½ by 11 inch paper. A copy for local reproduction is at the back of this regulation. The letters will be printed in red or black on a white background.

c. DA Form 5560-R may also be enlarged for use as a highway type sign at the entrance to installations and activities.

4-4. Enforcement

Failure to comply with the prescribed policy subjects Active Army and Reserve Component soldiers, family members, retirees, and appropriated and non-appropriated civilian personnel to a variety of penalties. The penalty depends on the nature of the violation, the status of the offender, and other relevant factors. Violation of Army policies subjects military personnel to a variety of possible administrative or disciplinary actions (for example, counseling, reprimand) and subjects civilian personnel to possible disciplinary actions. Repeat violations can also result in the removal of personnel from activities and barring from activities (for example, MWR facilities, youth activity center) or installations.

Chapter 5 Suicide Prevention and Psychological Autopsy

5-1. General

This chapter sets guidelines for establishing the Army Suicide Prevention Program (ASPP). This program—

- a.* Supports the Army's goal to reduce the suicide risk for AC and RC soldiers, Army civilians, and AC family members.
- b.* Establishes requirements for suicide risk identification training.
- c.* Outlines responsibilities for the ASPP.
- d.* Requires a psychological autopsy for specified deaths.

5-2. Army Suicide Prevention Program

A coordinated suicide prevention program will be established at every Army installation or community and separate activity. ASPPs will provide—

a. A suicide prevention education awareness program for both military and civilian leaders, managers, and supervisors, as well as family members. This program will train personnel in suicide risk identification and in procedures for crisis intervention and referral.

b. For the concentration of mental health and UMT resources to provide assistance as required to organizations and their members following the suicide of a soldier or Army civilian.

c. Assistance for families who have experienced the loss of a family member to suicide to the extent permitted by applicable laws and regulations.

5-3. Suicide Prevention Task Force

a. Each installation or community will establish, plan, implement, and manage the local ASPP.

b. Installation and community commanders may assign the suicide prevention mission to the installation HPC or may elect to establish a separate Suicide Prevention Task Force (SPTF) to function as a subcommittee of the HPC. When using the HPC to manage the ASPP, care must be taken so that suicide prevention does not take a second place to other responsibilities of the council. Responsibilities of HPC members, with respect to suicide prevention, must be clearly established. Where a separate SPTF has not been established, the HPC will perform all the duties given to the SPTF.

5-4. Coordination of helping services

a. ASPPs will make provision for the coordination of services provided by military and civilian helping agencies such as the Community Mental Health Service (CMHS), UMTs and the Chaplain Family Life Center, ACS, ADAPCP, American Red Cross, Youth Activities (YA), Child Development Services (CDS), local public schools or DODDS, and other agencies as appropriate.

b. This coordination will include information about and planning for programs and services as well as information pertaining to specific clients, if it is in the best interests of the client and done with regard for the requirements of client confidentiality. Non-Army persons are not permitted at meetings where information about individual cases is discussed without the permission of the individual concerned.

5-5. Training

a. Sequential and progressive suicide risk identification training will be integrated, without increasing the length of the program of instruction, into every Army leadership development course conducted by the Army school system. Specifically, this information will be provided at all levels of the Noncommissioned Officer Education System (NCOES) and officer leadership courses. As a minimum, students will receive a copy of DA Pam 600-70, or a locally produced information pamphlet containing essentially the same information. Students will also be given the opportunity to view the Army videotape "Suicide Prevention" (SAVPIN 701299DA (TVT 8-93)).

b. Formal training in suicide prevention and suicide risk identification will be presented as part of the unit level officer and NCO professional development courses.

c. Regularly scheduled installation level courses for civilian supervisors and designated CPO personnel will include training in suicide prevention.

d. Helping professionals (physicians, nurses, psychologists, social workers, chaplains, and counselors) and military police will receive regular inservice training in suicide prevention and crisis intervention.

e. Army mental health officers will provide the technical expertise for all suicide prevention education/awareness training. It is the role of mental health officers to "train the trainers" in all suicide prevention education programs.

f. UMTs (chaplains and chaplain assistants) will be trained by mental health officers in suicide prevention and suicide risk identification. Chaplains will assist mental health officers by providing suicide prevention education awareness training. This is a staff function at battalion or lower levels for the chaplain.

g. ACS personnel will be trained by mental health officers and will conduct a suicide prevention education program for family members. Inservice training in suicide prevention for the staffs of ACS, YA, and CDS will be coordinated by ACS officer/director and may be conducted by mental health officers or chaplains. ACS personnel will not be used to conduct suicide prevention training for military units or soldiers.

5-6. Family Member Suicide Prevention Program(FMSPP)

a. The FMSPP will be implemented by ACS in coordination with the SPTF or HPC. It is intended to promote an understanding of the potential for suicide in the community. The installation ACS officer will conduct an education awareness program for family members to help them recognize the signs of increased suicide risk, and to learn about referral sources for friends and family members. Educational programs will focus on three groups: parents, teenagers, and spouses.

b. ACS programs that include suicide prevention efforts will be coordinated with the overall suicide prevention efforts of the installation and the Army. ACS personnel will not provide crisis intervention services for suicidal individuals, except when needed during the providing of ACS services. ACS crisis intervention for persons who may be suicidal is limited to referral to the MTF or CMHS. ACS personnel will not provide counseling or clinical services to any individual or family where suicide may be a concern. Such individuals or families will be referred to the MTF or CMHS. Persons for whom suicide is not an immediate concern may also be referred to the UMT or the Chaplain Family Life Center.

5-7. Reporting and data analysis

a. Suicides and suspected suicides of AC and RC soldiers, AC family members, and Army civilians will be reported immediately to the military police for preparation a Serious Incident Report (SIR) to HQDA in accordance with AR 190-40. Those cases involving Army jurisdiction will be referred by the military police to the local United States Army Criminal Investigation Command (USACIDC) field element for appropriate investigation in accordance with AR 195-2.

b. The SPTF will collect and analyze local data on suicide attempts. (RCS exempt: AR 335-15, para 5-2 e(7).) This analysis will include the numbers of high, medium, and low lethality attempts by category of personnel and by unit. Data reflecting the reasons for suicide attempts will be collected.

5-8. Psychological autopsy

a. As provided in AR 195-2, a psychological autopsy will be conducted by a mental health officer and provided to USACIDC for deaths that meet the criteria established below. Subjects for investigation include all AC soldiers and all RC soldiers who are on active duty or active duty for training, and any active member of other armed forces of the United States assigned or attached to an Army unit or installation under any of the following conditions:

- (1) Confirmed or suspected suicides.
- (2) Single car motor vehicle accidents with no survivors, when requested by the commander of the local USACIDC office.
- (3) Accidents involving unusual or suspicious circumstances: for example, deaths due to substance abuse, or resulting from self-inflicted gunshot wounds.
- (4) All cases in which the mode (manner) of death is equivocal, that is, death cannot be readily established as natural, accidental, a suicide, or a homicide.

(5) Other cases when requested by the commander or special agent in charge of the local USACIDC office.

b. The report of the psychological autopsy (RCS exempt: AR 335-15, para 5-2 b(8)) will be included in the CID Report of Investigation as prescribed in AR 195-2.

c. Reports of psychological autopsies are sent by the preparing officer through the MACOM to each of the following:

(1) HQDA (SGPS-CP-F), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

(2) HQDA (DAPE-MPH), WASH DC 20310-0300.

(3) Commander, Walter Reed Army Institute of Research, ATTN:SGRD-UWI-A, WASH DC 20307-5100.

Appendix A References

Section I Required Publications

AR 30-1

The Army Food Service Program. (Cited in para 2-4.)

AR 40-501

Standards of Medical Fitness.(Cited in paras 2-3, 2-10, and 2-11.)

AR 165-20

Duties of Chaplains and Responsibilities of Commanders. (Cited in para 2-9.)

AR 190-40

Serious Incident Report. (Cited in para 5-7.)

AR 195-2

Criminal Investigation Activities.(Cited in para 5-8.)

AR 215-2

The Management of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentality's. (Cited in paras 2-3, 2-14, and 2-15.)

AR 350-15

Army Physical Fitness Program.(Cited in para 2-3.)

AR 600-9

The Army Weight Control Program.(Cited in para 2-5.)

AR 600-20

Army Command Policy and Procedures.(Cited in para 2-9.)

AR 600-85

Alcohol and Drug Abuse Prevention and Control Program. (Cited in para 2-6.)

AR 690-400

Employee Performance and Utilization. (Cited in para 2-13.)

DA Pam 350-18

The Individual's Handbook on Physical Fitness. (Cited in para 2-3.)

DA Pam 350-21

Family Fitness Handbook. (Cited in paras 2-3 and 2-14.)

DA Pam 600-63

(1-13) Fit to win (cited in para 2-16)

DA Pam 600-69

Unit Climate Profile Commander's Handbook. (Cited in para 2-6.)

DA Pam 600-70

U.S. Army Guide to the Prevention of Suicide and Self-destruction Behavior. (Cited in para 5-5.)

FM 21-20

Physical Fitness Training. (Cited in para 2-3.)

FM 26-2

Management of Stress in Army Operations. (Cited in para 2-7.)

FM 100-1

The Army. (Cited in para 2-9.)

Section II Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand the regulation.

AR 5-3

Installation Management and Organization

AR 40-25

Nutrition Allowances, Standards, and Education

AR 40-35

Preventive Dentistry

AR 40-216

Neuropsychiatry and Mental Health

AR 215-1

The Administration of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentality's

AR 360-5

Public Information

AR 360-61

Community Relations

AR 385-10

Army Safety Program

AR 600-21

Equal Opportunity in the Army

AR 608-1

Army Community Service Program

AR 608-10

Child Development Services

AR 672-1

Award of Trophies and Similar Devices in Recognition of Accomplishments

AR 690-990-2

Hours of Duty, Pay, and Leave

AR 930-5

American National Red Cross Service Program and Army Utilization

DA Pam 28-9

Unit Level Recreational Sports

DA Pam 350-15

Commander's Handbook on Physical Fitness

FM 21-20

Physical Fitness Training

FM 26-2

Management of Stress in Army Operations

DOD Directive 1010.10

Health Promotion

Section III
Prescribed Forms

DA Form 5560-R

No Smoking Except in Designated Smoking Areas. (Prescribed in para 4-3.)

DA Form 5560-1-R

Designated Smoking Area.(Prescribed in para 4-3.)

DEVELOPMENT OF AN INSTALLATION HEALTH PROMOTION PROGRAM

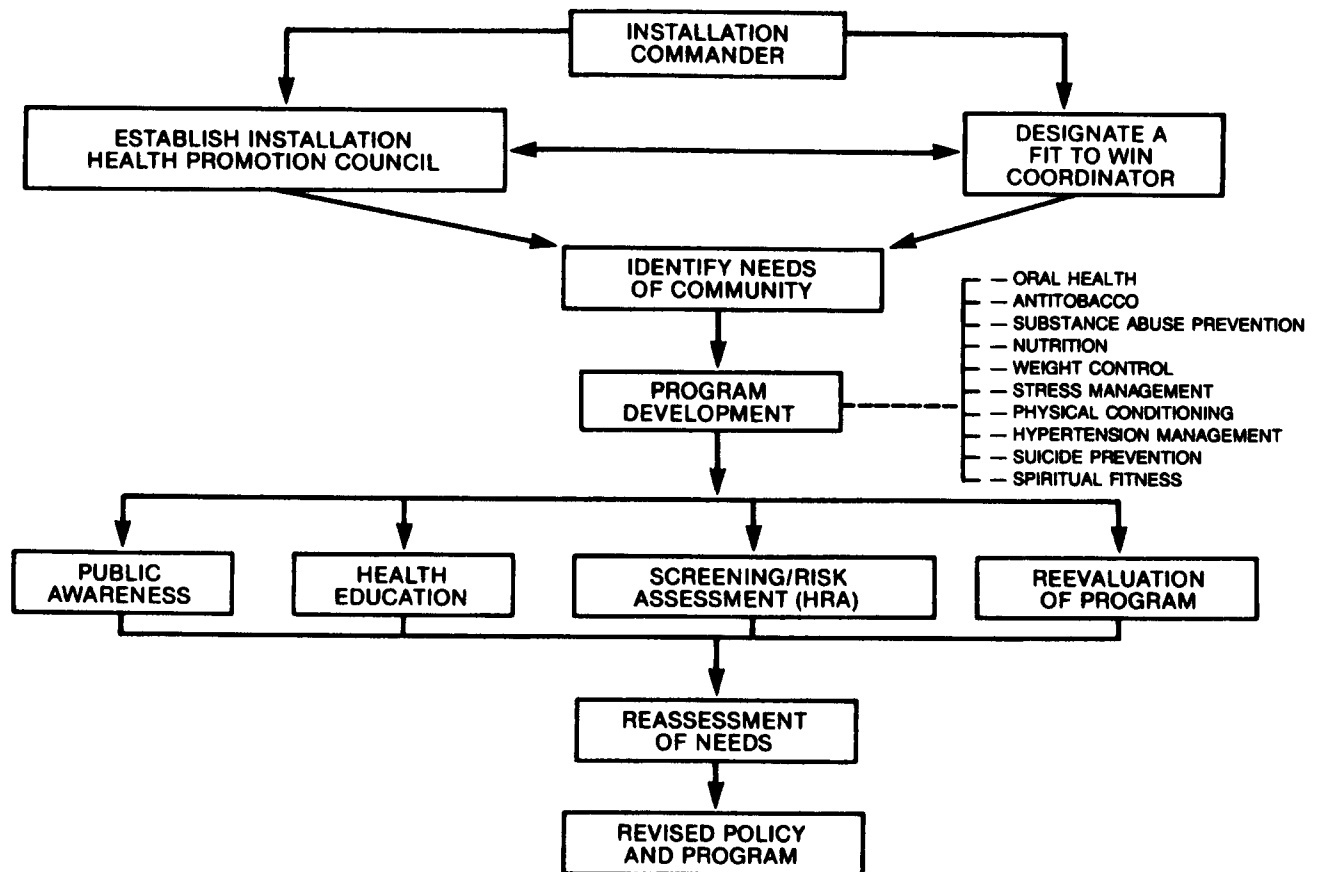


Figure 3-1. Development of an installation health promotion program

HEALTH PROMOTION PROCESS

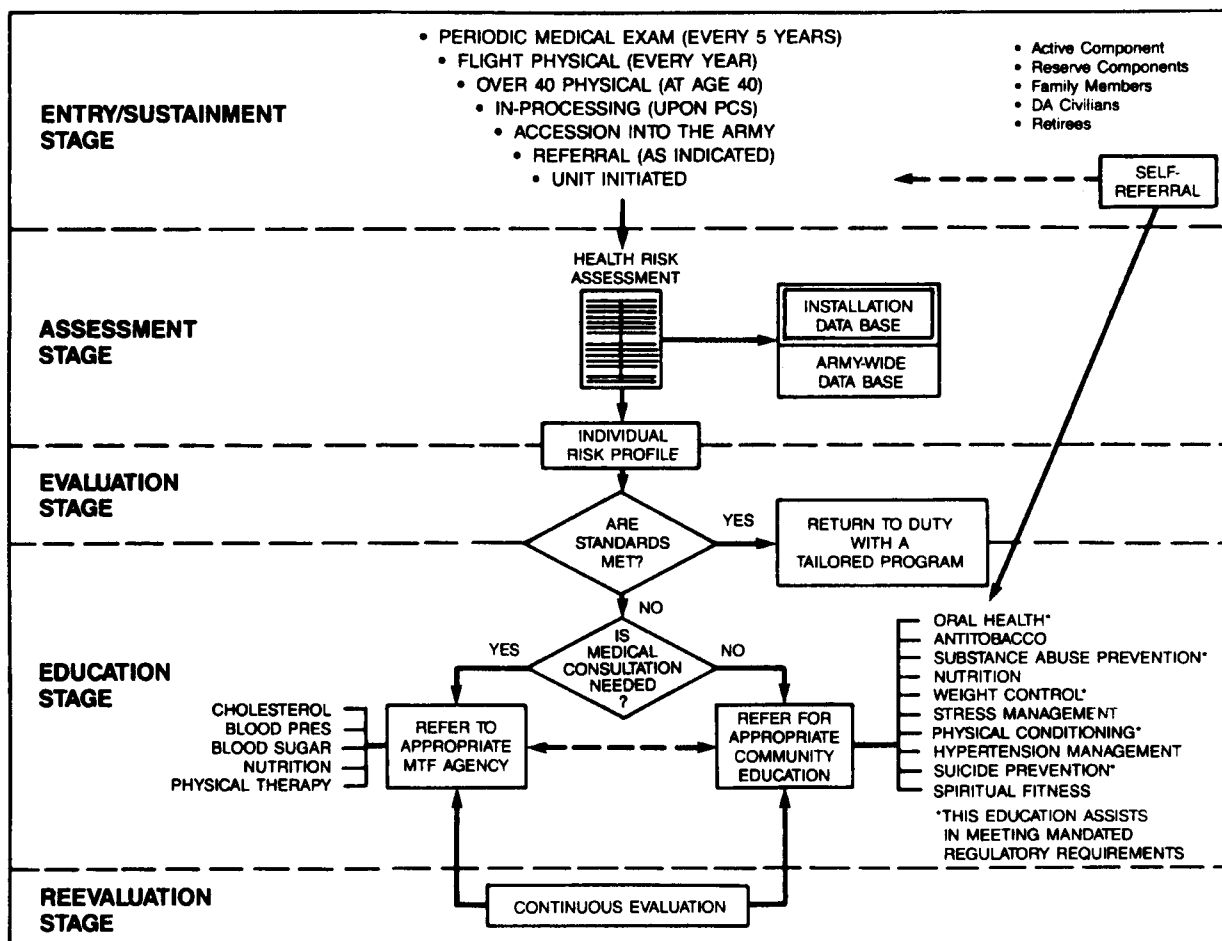


Figure 3-2. Health promotion process

Glossary

Section I Abbreviations

AC active component	CPA Chief of Public Affairs	NCO noncommissioned officer
ADAPCP Alcohol and Drug Abuse Prevention and Control Program	CPO civilian personnel officer	NCO noncommissioned Officer Education System
AMEDD Army Medical Department	CRD Community Recreation Division	OBC officer basic course
APFP Army Physical Fitness Program	DA Department of the Army	OSUT one-station unit training
APFT Army Physical Fitness Test	DCSLOG Deputy Chief of Staff for Logistics	PAO public affairs officer
ARC American Red Cross	DCSPER Deputy Chief of Staff for Personnel	PSC personnel service center
ARNG Army National Guard	DENTAC dental activity	RC Reserve Component (ARNG and USAR)
ARPERCEN U.S. Army Reserve Personnel Center	DOD Department of Defense	SIR Serious Incident Report
ASC Army Community Service	DODDS DOD Dependent Schools	SPTF Suicide Prevention Task Force
ASPP Army Suicide Prevention Program	DOL Director of Logistics	SRMT Suicide Risk Management Team
CCH Chief of Chaplains	DPCA Director of Personnel and Community Affairs	TJAG The Judge Advocate General
CDS Child Development Services	FORSCOM U.S. Forces Command	TPU troop program unit
CFSC U.S. Army Community and Family Support Center	FMSPP Family Member Suicide Prevention Program	TRADOC U.S. Army Training and Doctrine Command
CG commanding general	FSD Family Support Division	TSG The Surgeon General
CHEP Community Health Education Program	GSA General Services Administration	UCP unit climate profile
CINCUSAREUR Commander-in-Chief, U.S. Army Europe and Seventh Army	HIFIT Health Initiatives Fitness Team	UMT unit ministry team
CNGB Chief, National Guard Bureau	HPC Health Promotion Council	USACFSC U.S. Army Community and Family Support Center
COD Community Operations Division	HQDA Headquarters, Department of the Army	USACIDC U.S. Army Criminal Investigation Command
COE Chief of Engineers	IET initial entry training	USAR U.S. Army Reserve
CONUS continental United States	IRR Individual Ready Reserve	USASSC U.S. Army Soldier Support Center
CMHS Community Mental Health Service	MACOMs major Army commands	WESTCOM U.S. Western Command
	MEDDAC/MEDCEN Medical Department Activity/Medical Center	YA Youth Activities
	MTF medical treatment facility	
	NAF nonappropriated funds	

Section II

Terms

Alcohol and Drug Abuse Prevention and Control Program(ADAPCP)

A comprehensive program to eliminate substance abuse, including prevention, identification, education, and rehabilitation services. It includes nonresidential and residential treatment.

Antitobacco

The reduction, elimination, and deglamorization of tobacco product usage to improve the health and readiness of the Total Army.

Body composition

Quantification of the major structural components of the human body (fat and lean body mass).

Cardiorespiratory endurance

Functional capability of the heart, lungs, and blood vessels to take in and deliver oxygen to the working muscles and remove waste products. Essentially, it is the body's ability to receive and utilize oxygen in the cells for energy production.

Equivocal death

Cases where the available facts and circumstances do not immediately distinguish the mode of death are called "equivocal." Ambiguity or uncertainty existing among any of the four identified modes of death makes it equivocal.

Fitness Coordinator

Civilian health and fitness individual under the supervision of the installation commander with the responsibility of managing and coordinating the installation's program of health fitness.

Flexibility

Functional capability of the joint to move through a normal range of motion. It is highly specific and dependent on the muscles and connecting tissue surrounding a joint. Good flexibility is characterized by a freedom of movement, which contributes to ease of movement and economy of muscular effort.

Health

Optimal functioning with freedom from disease and abnormality.

Health care providers

Physicians, physician assistants, registered nurses, mental health specialists, occupational and physical therapists, and registered dietitians under the supervision of the unit surgeon or the commander of the medical treatment facility. For the purpose of this regulation, this term includes comparable personnel of U.S.Armed Forces and host nations.

Health promotion

Any combination of health education and related organizational, social, economic, or health care programs designed to improve or maintain health.

Hypertension identification

Actions to identify early those health risk factors such as high blood pressure, including smoking, cholesterol level, weight, family history, nutrition, and inactivity. These actions include early identification, provision of information regarding control and lifestyle factors, and treatment referral.

Master fitness trainer

Graduate of the 4-week course developed by the Soldier Physical Fitness School to train selected officers and noncommissioned officers in all aspects of the Army fitness program. They perform as unit advisers to commanders/supervisors on fitness programs, and they establish and monitor both unit and individual fitness programs.

Mental health officer

Trained mental health person who is credentialed or licensed as a psychiatrist, clinical or counseling psychologist, social worker, or psychiatric nurse specialist.

Mode (manner) of death

Five categories: natural, accidental, suicide, homicide, unknown. These categories are distinguished from the cause of death, for example, gunshot wound, heart disease.

Muscular endurance

Capability of a muscle, or group of muscles, to perform repeated functions for an extended period of time.

Muscular strength

Maximal force that can be exerted in a single voluntary contraction of a muscle or a muscle group. (Both muscular strength and endurance are related to age, selected general health factors, genetics, level of training, and level of effort.)

Nutrition

An appropriate intake of food that meets nutritional needs for calories and the macro- and micro-nutrients essential for health, and indispensable for individual well-being and productivity.

Physical fitness

Ability to cope within the physical demands of one's job, including the use of adequate reserves to cope with emergency situations. Components of physical fitness include cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition.

Psychological autopsy

Clarification of the nature of death focusing on the psychological aspects of the dead person. Primary purpose is to reconstruct and

understand the circumstances, lifestyle, and state of mind at the time of death.

Spiritual fitness

The development of those personal qualities needed to sustain a person in times of stress, hardship, and tragedy. These qualities come from religious, philosophical, or human values and form the basis for character, disposition, decision making, and integrity.

Stress management

Assistance provided to cope with the demands, real or perceived, from the environment and from within the individual.

Suicide attempt

Any overt act of self-destructive behavior not resulting in death.

Suicide prevention

The initiatives and activities taken to reduce the incidence of suicide and improve the identity ratio of at-risk people.

Unit ministry team

The chaplain and chaplain assistant who provide direct religious support for the religious needs of a unit.

Section III

Special Abbreviations and Terms

This section contains no entries

RESERVED

NO SMOKING



Except in Designated Smoking Areas

Sign should be posted **ONLY** at entrance(s) to Department of the Army owned or controlled buildings/facilities.
DA FORM 5560-R, AUG 86

Designated Smoking Area

Unclassified

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Student Handout 3

Extracted Material from AR 600-85

This student handout contains 2 pages of extracted material from AR 600-85, Army Substance Abuse Program (ASAP):

Topic	Pages
SH-3, Extracted Material from AR 600-85, Army Substance Abuse Program (ASAP)	SH-3-1

Disclaimer: The training developer downloaded this extract from <http://155.217.58.58/atdls.htm>. The text may contain passive voice, misspellings, grammatical errors, etc., and may not be in compliance with the Army Writing Style Program.

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Personnel—General

Army Substance Abuse Program (ASAP)

**Headquarters
Department of the Army
Washington, DC
1 October 2001**

UNCLASSIFIED

SUMMARY of CHANGE

AR 600-85

Army Substance Abuse Program (ASAP)

This revision--

- o Changes the name of the Army's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) to the Army Substance Abuse Program (ASAP) (title page).
- o Designates and clarifies command and clinical responsibilities at all levels. Commands will provide leadership and supervision for the non-clinical elements of the ASAP, with primary focus on installations' prevention and education programs. Counseling and treatment services provided by the ASAP clinical staff will be overseen by The Surgeon General (TSG), with local supervision by the Medical Treatment Facility commander (para 1-6 and 1-7).
- o Retains the Alcohol and Drug Control Officer as the single point of contact for administrative non-clinical elements of the ASAP at the installation (para.1-16 b (1))0.
- o Modifies the Clinical Director's rating scheme so that the rating will be accomplished by the Clinical Consultant, with intermediate rating by the rater of the installation Alcohol and Drug Control Officer, and senior rating by the Deputy Commander for Clinical Services (para. 1-10e).
- o Allows authority for the clinical portions of the ASAP to be in the hands of appropriate personnel, while ensuring the needs of the command continue to be met. Makes clear that only a qualified clinician can design and implement treatment. Clinical disagreements will be resolved jointly by a Colonel (that is, the soldier's commander may appeal to the first Colonel in the chain of command) and the Medical Treatment Facility commander, who has the final authority. Retains the unit commander's responsibility to determine rehabilitation success or failure as a function of performance (para 3-10).
- o Assigns oversight of the clinical segment of the ASAP to TSG and the U.S. Army Medical Command who must approve all changes regarding clinical issues. The Director, Army Center for Substance Abuse Programs is responsible for the oversight of the non-clinical components (para 1-6 and 1-7).
- o Assigns management and oversight functions of the drug testing labs, to include pre-screening lab operations, to The Surgeon General and the U.S. Army Medical Command. The Director, Army Center for Substance Abuse Programs is responsible for the management and oversight of the command elements of the biochemical testing program (para 1-6 and 1-7).
- o Establishes policies and procedures for fitness for duty testing for alcohol (para. 1-33).
- o Mandates that all soldiers who are identified as illegal drug users will be processed for administrative separation (para. 1-35).

- o Requires all Active Component soldiers be tested for drugs at a rate which approximates one unannounced random sample per year (para. 8-2).
- o Requires soldiers who are command referred and enrolled in the ASAP be flagged according to AR 600-8-2 (para. 5-7).
- o Promotes the concept of risk reduction to target potential problems before they become crises that place families, careers, productivity, and readiness in jeopardy (para. 2-5).
- o Expands the Army's civilian Drug-free Federal Workplace drug testing program and implements the Department of Transportation, Commercial Driver's License Program and Controlled Substances and Alcohol Use Testing (chap 14).

Effective 15 October 2001

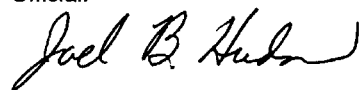
Personnel—General

Army Substance Abuse Program (ASAP)

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This publication publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This regulation has been extensively revised and governs the ASAP. It identifies Army policy on alcohol and other drug abuse, and assigns responsibilities for implementing the program.

Applicability. This regulation applies to the Active Army, the Army National

Guard of the United States, the Army National Guard, the U.S. Army Reserve, and Department of the Army Civilian Employees. Chapter 12 deals specifically with the Army National Guard of the United States, while chapter 13 deals with Army Reserve soldiers. Chapter 14 deals with Department of the Army civilian employees, military and civilian employee family members, and military retirees.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff for Personnel (DCSPER). The DCSPER has the authority to approve exceptions to this regulation that are consistent with controlling law and regulations. The DCSPER may delegate this approval authority in writing to a division chief within the proponent's agency in the rank of Colonel or the civilian equivalent

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of forms other than Department of the Army forms

are prohibited without prior approval of the Deputy Chief of Staff for Personnel, HQDA (ATTN: DAPE-HR-ASAP), Washington, DC, 20310-0300.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (ATTN: DAPE-HR-ASAP), Washington, DC 20310-0300. Changes to clinical aspects of this regulation must be approved by USAMEDCOM.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for Active Army, Army National Guard, and U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1

General, page 1

Purpose • 1–1, *page 1*

References • 1–2, *page 1*

Explanation of abbreviations and terms • 1–3, *page 1*

The Deputy Chief of Staff for Personnel (DCSPER) • 1–4, *page 1*

The Director of Human Resources (DHR) • 1–5, *page 1*

The Director, Army Substance Abuse Program • 1–6, *page 1*

The Surgeon General (TSG)/USAMEDCOM • 1–7, *page 2*

The Judge Advocate General (TJAG) • 1–8, *page 3*

Commanders of regional medical commands (RMCs) • 1–9, *page 3*

Commanders of MEDDAC/MEDCENs • 1–10, *page 3*

The Chief, National Guard Bureau (CNGB) • 1–11, *page 3*

The Chief, Army Reserve (CAR) • 1–12, *page 3*

Commanders of MACOMs with installation, community or equivalent organizations • 1–13, *page 3*

*This regulation supersedes AR 600-85 dated 3 November 1986 and rescinds DA Form 5018-R, dated November 1981.

Contents—Continued

ADCOs at MACOMs • 1–14, *page 4*
Commanders of other MACOMs without installation, community or equivalent organizations • 1–15, *page 4*
Installation, community, garrison, or equivalent commanders • 1–16, *page 4*
Installation ADCOs • 1–17, *page 5*
Installation EAPCs and PCs • 1–18, *page 6*
Installation IBTCs • 1–19, *page 6*
Installation CDs • 1–20, *page 6*
Installation PMs • 1–21, *page 6*
Installation safety officers • 1–22, *page 7*
Installation risk reduction coordinators • 1–23, *page 7*
Installation prevention team (IPT) members • 1–24, *page 7*
Commanders of corps, division, brigade, and battalions • 1–25, *page 7*
Commanders of companies, detachments, and equivalent units • 1–26, *page 7*
Unit prevention leaders (UPLs) • 1–27, *page 7*
Manpower staffing • 1–28, *page 8*
Program authority • 1–29, *page 8*
ASAP mission/objectives • 1–30, *page 8*
ASAP principles • 1–31, *page 8*
ASAP eligibility criteria • 1–32, *page 9*
Alcohol policies and controls • 1–33, *page 9*
Alcohol sanctions • 1–34, *page 10*
Illegal drugs and sanctions • 1–35, *page 10*
Law enforcement relationship to the ASAP • 1–36, *page 11*

Chapter 2

Alcohol and Other Drug Abuse Prevention, *page 11*

Section I

General, page 11

Definition of prevention • 2–1, *page 11*
Alcohol and other drug abuse prevention objectives • 2–2, *page 11*
Prevention policies • 2–3, *page 11*

Section II

Prevention Strategies, page 12

Community-based processes/initiatives • 2–4, *page 12*
Risk reduction program (RRP) • 2–5, *page 12*
Substance abuse prevention and awareness training • 2–6, *page 12*
Evaluation of prevention initiatives • 2–7, *page 13*
Alcohol and other drug abuse control actions • 2–8, *page 13*
Law enforcement and drug suppression activities • 2–9, *page 13*
Prevention, education, and training expenditures • 2–10, *page 13*

Chapter 3

Identification, Referral, Screening, Evaluation, and the Rehabilitation Team, *page 13*

Identification • 3–1, *page 14*
Voluntary (self-identification) • 3–2, *page 14*
Commander/supervisor identification • 3–3, *page 14*
Biochemical identification • 3–4, *page 14*
Medical identification and investigation and/or apprehension • 3–5, *page 14*
Medical Review Officers • 3–6, *page 14*
Commander's actions for referring soldiers suspected of alcohol or drug abuse • 3–7, *page 15*
Self referrals • 3–8, *page 15*
Other referrals • 3–9, *page 15*
Screening • 3–10, *page 15*

Contents—Continued

Medical evaluation • 3–11, *page 16*

Rehabilitation team • 3–12, *page 16*

Chapter 4

Soldier Rehabilitation Process, *page 16*

Section I

Introduction, page 16

General • 4–1, *page 16*

Rehabilitation objectives • 4–2, *page 17*

Rehabilitation elements • 4–3, *page 17*

Rehabilitation team concept • 4–4, *page 17*

Section II

Rehabilitation Procedures, page 17

Referral methods, biopsychosocial assessment, and treatment determination • 4–5, *page 17*

Rehabilitation/treatment program • 4–6, *page 17*

Determining rehabilitation progress • 4–7, *page 17*

Type and frequency of treatment • 4–8, *page 18*

Rehabilitation/treatment appointments • 4–9, *page 18*

Return to duty • 4–10, *page 18*

Reassignment while enrolled in the ASAP (permanent change of station loss or gain) • 4–11, *page 18*

Self-help support organizations • 4–12, *page 18*

Transfer to VA medical facilities • 4–13, *page 19*

Unacceptable rehabilitation modalities • 4–14, *page 19*

Clinical privilege and certification requirements • 4–15, *page 19*

Section III

Detoxification, page 19

General • 4–16, *page 19*

Line of duty determination • 4–17, *page 19*

Quality improvement, clinical staff competency • 4–18, *page 19*

Chapter 5

Personnel Actions During Rehabilitation, *page 19*

General • 5–1, *page 19*

Deployment • 5–2, *page 19*

Leave policy during rehabilitation • 5–3, *page 19*

Suspension from duty • 5–4, *page 19*

Separation actions for alcohol and other drug abuse • 5–5, *page 20*

Reenlistment during enrollment in the ASAP • 5–6, *page 20*

Suspension of favorable actions • 5–7, *page 20*

Chapter 6

Legal Aspects, Limited Use Policy, and Confidentiality, *page 20*

Section I

Introduction, page 20

Overview • 6–1, *page 20*

Biochemical testing • 6–2, *page 20*

Section II

Limited Use Policy, page 21

Objective • 6–3, *page 21*

Definition of “Limited Use Policy” • 6–4, *page 21*

Implementation of limited use • 6–5, *page 22*

Contents—Continued

Separation actions • 6–6, *page 23*

Section III

Military Confidentiality, page 23

Confidentiality of military patient ASAP information within the Armed Forces • 6–7, *page 23*

Confidentiality of military client ASAP information outside the Armed Forces • 6–8, *page 24*

Authority • 6–9, *page 24*

Penalties • 6–10, *page 24*

Section IV

Releasing ASAP Information to the Media, page 24

Releasing information to news media • 6–11, *page 24*

Guidelines for releasing information • 6–12, *page 24*

Administration • 6–13, *page 24*

Chapter 7

Special Provisions for Military Personnel in Critical Safety or Security Positions, page 24

General • 7–1, *page 24*

Personnel in sensitive security positions • 7–2, *page 25*

Personnel reliability program (PRP) • 7–3, *page 25*

Reporting disqualifying information • 7–4, *page 25*

PRP urinalysis testing requirements • 7–5, *page 25*

Aviation personnel and alcohol and drug abuse • 7–6, *page 25*

Chapter 8

Biochemical Testing, page 26

Objectives • 8–1, *page 26*

Policy • 8–2, *page 26*

Biochemical testing programs • 8–3, *page 26*

Retesting of positive FTDTL specimens • 8–4, *page 27*

Requesting urinalysis documents • 8–5, *page 27*

Chapter 9

Management Information System, page 28

General • 9–1, *page 28*

ASAP reporting procedures • 9–2, *page 28*

USAMEDCOM reporting requirements • 9–3, *page 28*

Department of Transportation (DOT) reporting requirements • 9–4, *page 28*

ASAP patient medical records • 9–5, *page 28*

ASAP patient medical record filing procedures • 9–6, *page 29*

Management information feedback reports • 9–7, *page 29*

Chapter 10

Program Evaluation, page 29

Scope • 10–1, *page 29*

Staff assistance inspection (SAI) and Installation biochemical testing program inspection (IBTPI) • 10–2, *page 30*

Chapter 11

ASAP Non-clinical and Clinical Staff Training, page 30

General • 11–1, *page 30*

Non-clinical DA sponsored staff training • 11–2, *page 30*

Leadership training and schools • 11–3, *page 30*

Training products • 11–4, *page 30*

ASAP staff certification • 11–5, *page 30*

Clinical USAMEDCOM sponsored training • 11–6, *page 30*

Contents—Continued

Deployment training • 11–7, *page 31*

Chapter 12

Army Substance Abuse Program (ASAP) in the Army National Guard of the United States (ARNGUS),
page 31

Section I

General, page 31

Scope • 12–1, *page 31*

Applicability • 12–2, *page 31*

Section II

Scope of Duties, page 31

The Director, Army National Guard (ARNG) • 12–3, *page 31*

The Chief Surgeon, ARNG • 12–4, *page 31*

The Director, Counterdrug Directorate, National Guard Bureau (NGB-CD) • 12–5, *page 31*

The Chief, Substance Abuse Branch • 12–6, *page 31*

The State Adjutants General • 12–7, *page 32*

State ADCOs • 12–8, *page 32*

Major Army Command Alcohol Drug Control Officers • 12–9, *page 32*

Unit Prevention Leaders (UPLs) • 12–10, *page 32*

Section III

Policies and Procedures, page 32

Policies • 12–11, *page 32*

Funding considerations • 12–12, *page 33*

Alcohol Drug Intervention Council (ADIC) • 12–13, *page 33*

Referral of alcohol and illegal drug abusers to the ARNG ASAP • 12–14, *page 33*

Rehabilitation • 12–15, *page 34*

State MROs • 12–16, *page 34*

Administratively separating drug abusers • 12–17, *page 34*

Biochemical testing guidance • 12–18, *page 34*

Management information system • 12–19, *page 35*

Evaluation • 12–20, *page 35*

Quota allocation process • 12–21, *page 35*

Military justice • 12–22, *page 35*

Chapter 13

Army Substance Abuse Program (ASAP) in the U.S. Army Reserve (USAR), *page 35*

Section I

General, page 35

Scope • 13–1, *page 35*

Applicability • 13–2, *page 35*

Section II

Duties, page 35

The Chief, Army Reserve (CAR) • 13–3, *page 35*

Commander, USAR Personnel Command (AR-PERSCOM) • 13–4, *page 35*

Commanders of area commands • 13–5, *page 36*

Area command ADCOs • 13–6, *page 36*

Commanders of major U.S. Army Reserve commands (MUSARCs) • 13–7, *page 36*

MUSARC ADCOs • 13–8, *page 36*

Section III

Policies and Procedures, page 36

Contents—Continued

Policies • 13–9, *page 36*
Prevention and control • 13–10, *page 37*
Referral of alcohol and illegal drug users in the USAR ASAP • 13–11, *page 37*
Rehabilitation • 13–12, *page 38*
Medical Review Officers • 13–13, *page 38*
Biochemical testing guidance • 13–14, *page 38*
Management information system • 13–15, *page 38*
Evaluation • 13–16, *page 39*
Military justice • 13–17, *page 39*

Chapter 14

Army Substance Abuse Program (ASAP) Civilian Services, *page 39*

Section I

Introduction, page 39

Policies • 14–1, *page 39*
Eligibility • 14–2, *page 40*
Labor relations • 14–3, *page 40*

Section II

Areas of Responsibility, page 40

MACOM employee assistance program administrator (EAPA)/prevention program administrator (PPA) • 14–4, *page 40*
Installation ADCOs • 14–5, *page 40*
Civilian Personnel Advisory Center (CPAC) • 14–6, *page 40*
Civilian personnel operations center (CPOC) • 14–7, *page 41*
Installation EAPCs • 14–8, *page 41*
Supervisors of DA civilians • 14–9, *page 41*

Section III

Employee Assistance Program (EAP), page 41

Screening and referral • 14–10, *page 41*
Medical evaluations • 14–11, *page 41*
Patient costs • 14–12, *page 42*
Participation of family members (military or civilian) • 14–13, *page 42*
Confidentiality of patient records • 14–14, *page 42*
Confidentiality of alcohol and other drug tests results • 14–15, *page 42*

Section IV

Drug-free Federal Workplace (DFW) Program, page 43

Objectives • 14–16, *page 43*
Applicability • 14–17, *page 43*
DFW program drug testing categories • 14–18, *page 43*
Drug testing procedures • 14–19, *page 43*
Drug-free Federal Workplace Testing Designated Positions • 14–20, *page 43*
Identification of additional TDPs • 14–21, *page 44*
Relationship with disciplinary and adverse actions • 14–22, *page 44*
Specimen collection • 14–23, *page 44*
Medical review and reporting of DFW test results • 14–24, *page 44*
Contractor requirements • 14–25, *page 44*
Additional Testing Designated Positions within the U.S. Army Corp of Engineers • 14–26, *page 45*

Section V

DOT Drug and Alcohol Testing Program, page 45

Objectives • 14–27, *page 45*
Applicability • 14–28, *page 45*

Contents—Continued

Safety-sensitive functions • 14–29, *page 45*
DOT prohibited conduct and consequences • 14–30, *page 45*
Department of Transportation categories of testing • 14–31, *page 45*
Department of Transportation testing procedures and required education and training • 14–32, *page 45*
Department of Transportation frequency of random alcohol and other drug testing • 14–33, *page 45*
Specimen collection for DOT drug testing • 14–34, *page 45*
Medical review and the reporting of DOT drug test results • 14–35, *page 46*
Alcohol testing • 14–36, *page 46*
SAP evaluation, referral, and follow-up • 14–37, *page 46*
DOT management information requirements • 14–38, *page 46*

Appendixes

- A.** References and Terms, *page 47*
- B.** Unit Commander's guide to the Army Substance Abuse Program (ASAP), *page 50*
- C.** MANAGEMENT CONTROL EVALUATION CHECKLIST, *page 55*
- D.** PROGRAM EVALUATION TEST QUESTIONS, *page 55*
- E.** Standing Operating Procedures (SOP) For Urinalysis Collection, Processing and Shipping, *page 57*
- F.** Program Evaluation Test Questions, *page 62*

Figure List

Figure B–1: Alcohol and/or other drug abuse process., *page 53*
Figure B–2: Positive drug test process., *page 54*

Glossary

Chapter 1

General

1–1. Purpose

This regulation prescribes policies and procedures to implement, administer, and evaluate the Army Substance Abuse Program (ASAP).

1–2. References

Required and related references and prescribed and referenced forms are listed in Appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. The Deputy Chief of Staff for Personnel (DCSPER)

The DCSPER will—

- a.* Integrate, coordinate, and approve all policies pertaining to the ASAP.
- b.* Exercise General Staff responsibility for plans, policies, programs, budget formulation, and related non-clinical research and program evaluation pertaining to alcohol and other drug abuse in the Army.

1–5. The Director of Human Resources (DHR)

The DHR will—

- a.* Provide guidance and leadership on all non-clinical alcohol and other drug policy issues.
- b.* Manage the substance abuse program budget.
- c.* Exercise staff leadership and supervision over the ASAP.
- d.* Ensure the Risk Reduction Program (RRP) interfaces with related functional areas within DHR's responsibilities (that is, suicide, sexual harassment, violence prevention, health promotion, equal employment opportunity, and substance abuse) and coordinate RRP activities with other related Department of Defense (DOD), Department of the Army (DA), and civilian agencies (for example, safety and law enforcement offices, chaplains, and so forth).
- e.* Oversee the Army's biochemical testing program.

1–6. The Director, Army Substance Abuse Program

The Director, ASAP will—

- a.* Supervise the ASAP policy staff and direct the operations of the Army Center for Substance Abuse Programs (ACSA).
- b.* Develop Army non-clinical goals and policies.
- c.* Review, assess, and recommend policy changes as appropriate.
- d.* Interpret ASAP policy in response to inquiries from major Army commands (MACOMs), their subordinate commands, other uniformed Services, DOD, and other Federal agencies.
- e.* Prepare budget submissions, direct allocation of funds, monitor execution of resources, and serve as the functional budget program manager for the ASAP.
- f.* Oversee programs, develop plans, formulate budgets, and provide technical assistance and training for ASAP civilian services.
- g.* Maintain liaison between the Army and the other uniformed Services, other Federal agencies, and the private sector.
- h.* Provide operational guidance, monitoring, and oversight of the worldwide ASAP for the non-clinical elements of the program.
- i.* Consolidate all alcohol and other drug statistics, to include urinalysis data, and provide periodic reports to Department of Health and Human Services (DHHS), DOD, the Army Staff, MACOMs, and installation Alcohol and Drug Control Officers (ADCOS).
- j.* Establish and maintain program-level evaluation plans, measures, data collection, analyses, and reporting procedures for implementation at Army, MACOM, and installation levels.
- k.* Publish an ASAP Evaluation Plan (AEP), which will be updated every 3 years, or as ASAP changes dictate.
- l.* Evaluate the non-clinical functions of ASAP programs and services every 2/3 years.
- m.* Provide technical assistance in the use of automation and other emerging technologies for use in substance abuse programs.
- n.* Develop, establish, administer, and evaluate non-clinical alcohol and other drug abuse prevention, education, and training programs.
- o.* Design, develop, and implement special alcohol and other drug abuse training and educational programs for non-

clinical ASAP staff. Establish selection criteria and provide allocations for nominees to attend special training sponsored by DA.

p. Conduct assistance visits to MACOMs and installations to assess implementation of ASAP policies and procedures.

q. Maintain non-clinical staffing inventory data for the ASAP worldwide.

r. Serve as DA's lead agency on all issues related to drug demand reduction (non-clinical) programs and alcohol abuse prevention.

s. Serve as DA's proponent for the RRP that complements the Army Safety Center Risk Management Process.

t. Manage all operational aspects of the RRP.

u. Coordinate with appropriate DOD, DA, and civilian agencies in the conduct of the RRP.

v. Serve as the subject matter expert supporting the Army Civilian Training and Education System with training development and analysis for all non-clinical ASAP positions.

w. Ensure DA programs comply with the Office of National Drug Control Policy (ONDCP) and the National Drug Control Strategy.

x. Provide services such as marketing, training, data processing, analysis, evaluation, guidebooks, operational guidance products and reports to DOD, DA, MACOMs, and installations.

y. Administer the duties of the Contract Officer Representative (COR) addressed in the Memorandum of Understanding between U.S. Army Medical Command and the Office of the Deputy Chief of Staff for Personnel outlining duties and responsibilities regarding the ACSAP contracted Adolescent Substance Abuse Counseling Services (ASACS) program.

z. Manage the command elements of the biochemical-testing program.

aa. Inspect all command elements of the biochemical-testing program for compliance with regulation.

bb. Provide operational guidance regarding alcohol testing, urine collection, chain of custody, handling and shipping, training of Unit Prevention Leaders (UPLs) and Installation Biochemical Test Coordinators (IBTCs).

cc. Collect and monitor all biochemical statistical data for the Director of Human Resources (DHR).

dd. Manage and distribute drug testing quota allocations.

1-7. The Surgeon General (TSG)/USAMEDCOM

TSG will—

a. Develop policies, standards, and doctrine pertaining to all clinical elements of the ASAP, which include medical identification, referral, screening, evaluation, treatment, and follow-up.

b. Program, manage, and provide clinical resources, funds, and professional services as required to administer the clinical elements of the ASAP at all levels.

c. Provide input for content and assist in providing clinical aspects of prevention, education, and training.

d. Provide continuing education and training for assigned ASAP clinical staff.

e. Conduct credentials review and serve as approval authority for ASAP clinical staff.

f. Manage the drug testing labs that support the Army's Biochemical Testing Program (to include pre-screening lab operations).

g. Provide operational guidance for drug testing labs that support the Army's Biochemical Testing Program (to include pre-screening lab operations).

h. Manage drug testing lab contracts that support the Army's Biochemical Testing Program as directed by the DCSPER.

i. Provide all necessary biochemical statistical data to Director, ACSAP.

j. Exercise staff supervision over the ASAP medical and clinical elements through the specific geographic area regional medical commands (RMCs).

k. Coordinate ASAP clinical policy with the Director, ASAP.

l. Develop medical aspects of alcohol and other drug abuse prevention, education, and training, which include health care personnel, and assessment of deployable units.

m. Develop and promote wellness/fitness and health promotion activities supporting the garrison in coordination with alcohol and other drug abuse demand reduction and prevention efforts of the ASAP.

n. Evaluate clinical functions and provide evaluation summaries to the Director, ASAP for integration into a total program assessment.

o. Provide Medical Review Officer (MRO) services for military and civilian personnel drug testing.

p. Provide Substance Abuse Professional (SAP) services for civilian alcohol testing.

q. Provide for three Army biochemist (71Bs) at each Army Forensic Drug Testing Laboratory to fill the positions of Commander, Deputy Commander, and Executive Officer.

1–8. The Judge Advocate General (TJAG)

TJAG will—

- a.* Evaluate the legal aspects of the ASAP.
- b.* Review forensic specimen handling procedures (chain of custody) and other biochemical testing program elements for legal sufficiency.

1–9. Commanders of regional medical commands (RMCs)

Commanders of RMCs —

- a.* Provide oversight for the ASAP counseling centers staffed by the Medical Department Activity (MEDDAC) and/or Medical Centers (MEDCENS) within the RMC's area of responsibility, through their appointed ASAP RMC point of contacts (POCs).
- b.* Ensure medical resources are available to conduct the required medical review of military and civilian drug tests results.
- c.* Ensure the clinical services provided by all ASAP counseling centers within their geographical area of responsibility satisfy the current Accreditation Standards for Hospitals in accordance with current DOD policy directives.

1–10. Commanders of MEDDAC/MEDCENS

Commanders of MEDDAC/MEDCENS will—

- a.* Provide adequate and appropriate administrative support, medical services, clinical support, and consultation services necessary for quality clinical services in support of the ASAP counseling centers.
- b.* Ensure the ASAP counseling centers in their areas of responsibility comply with appropriate medical guidance for accreditation.
- c.* Exercise staff supervision and management of clinical staff assigned to the ASAP.
- d.* Appoint on orders a physician as Clinical Consultant (CC) to provide medical and clinical consultation and to ensure the quality of all clinical professional services in the area of addiction medicine.
- e.* Designate a civilian Clinical Director (CD), who generally will be rated by the CC, with intermediate rating by the rater of the installation ADCO, and senior rated by the Deputy Commander for Clinical Services.
- f.* Designate a qualified SAP to be responsible for duties identified in Department of Transportation/Federal Highway Administration (DOT/FHWA) guidance in 49 CFR, Parts 40 and 382, governing alcohol and other drug testing of civilians requiring commercial driver's licenses.
- g.* Ensure close coordination of the clinical aspects with the non-clinical aspects of ASAP.

1–11. The Chief, National Guard Bureau (CNGB)

The CNGB will—

- a.* Recommend policies and operational tasks to the DCSPER regarding ARNG soldiers and their families' participation in the ASAP. (See chap 12 of this regulation for specific ARNG guidance.)
- b.* Ensure ARNG units comply with ASAP policies.
- c.* Advise the DCSPER regarding alcohol and other drug abuse and the impact of the ASAP on the ARNG.

1–12. The Chief, Army Reserve (CAR)

The CAR will—

- a.* Recommend policies and operational tasks to the DCSPER regarding the participation of USAR soldiers and their families' participation in the ASAP. (See chap 13 of this regulation for specific USAR guidance.)
- b.* Ensure USAR units comply with ASAP policies.
- c.* Advise the DCSPER regarding alcohol and other drug abuse and the impact of the ASAP on the USAR.

1–13. Commanders of MACOMs with installation, community or equivalent organizations

Commanders of MACOMs will—

- a.* Resource and staff the MACOM ASAP and support both Major Subordinate Commands (MSCs) and installation programs to achieve the objectives of the program and to respond to the needs of the commanders and supervisors.
- b.* Designate an ADCO and an EAP Administrator (EAPA)/Prevention Program Administrator (PPA) as centralized

points of contact in their headquarters to coordinate administrative and resource issues pertaining to the employee assistance and prevention components of the ASAP.

- c.* Exercise staff leadership and supervision through the MACOM ADCO.
- d.* Designate a civilian personnel specialist to coordinate all civilian personnel issues pertaining to ASAP civilian services, the EAP, and civilian alcohol and drug testing program requirements.
- e.* Coordinate and monitor the implementation of installation and activity biochemical testing programs under their jurisdiction.
- f.* Allocate all available urinalysis quotas within their command and monitor utilization.
- g.* Establish and maintain contact and coordination with servicing laboratories.
- h.* Establish and implement supporting and supplemental plans consistent with the objectives and procedures established by the Army Evaluation Plan (AEP).
- i.* Additionally, the Commanding General, U.S. Army Training and Doctrine Command will integrate DCSPER-approved training programs and training support materials into all levels of alcohol and other drug abuse prevention training conducted at non-clinical service schools and training centers throughout the Army.

1–14. ADCOs at MACOMs

MACOM ADCOs will—

- a.* Provide continuous program management, planning, programming, budgeting, monitoring and evaluation of the non-clinical ASAP elements as applicable.
- b.* Conduct annual on-site evaluations of all non-clinical aspects of all MSCs and installation programs.
- c.* Collect and maintain necessary management information to assess program effectiveness.
- d.* Ensure additional personnel are designated (as appropriate) to manage and coordinate all matters pertaining to ASAP prevention, education, and biochemical testing.
- e.* Ensure all installations, organizations, agencies, and activities under their jurisdiction provide continuing alcohol and other drug abuse prevention and education.
- f.* Supervise the EAPA/PPA.

1–15. Commanders of other MACOMs without installation, community or equivalent organizations

Commanders of other MACOMs will—

- a.* Designate an ADCO as a centralized point of contact in their headquarters to coordinate all matters pertaining to ASAP.
- b.* Additionally, the Commander, U.S. Army Criminal Investigation Command (USACIDC) will—
 - (1) Conduct and support operations, programs, and activities designed to deter, prevent, and suppress traffic in controlled substances in conjunction with appropriate State, Federal, host country, and international law enforcement agencies.
 - (2) Provide periodic drug assessment reports to the Director, ASAP for both worldwide and specific regions or commands for use in determining resource requirements and developing drug deterrence, enforcement and prevention strategies. (Refer to AR 195-2 for specific responsibilities pertaining to the investigation of drug offenses and crime prevention surveys.)
 - (3) Ensure subordinate commands coordinate with the local ADCO concerning urinalysis results and related trends before threat assessments are presented to a MACOM or installation commander.
- c.* The Commander, U.S. Army Corps of Engineers (USACE) is delegated the authority to promulgate a regulation to address Corps-specific policies, responsibilities, and procedures related to the ASAP. The USACE regulation will comply with the policies and programs contained in this regulation. The Commander, USACE may delegate the responsibilities for implementing AR 600-85 to fit the unique organizational structure of the Corps. Prior to publication, the USACE regulation will be submitted to the Director, ASAP for review and approval.

1–16. Installation, community, garrison, or equivalent commanders

Commanders will—

- a.* Establish a local ASAP and ensure that the full range of ASAP services, to include the civilian alcohol and other drug testing programs are funded and available to all eligible personnel. The non-clinical and clinical elements of the ASAP should be operationally integrated and should be collocated to achieve maximum command/soldier readiness.
- b.* Designate each of the following positions:
 - (1) An ADCO to function as the installation ASAP single point of contact for administrative functions of the non-clinical aspects of the ASAP.
 - (2) A Prevention Coordinator (PC) to administer the prevention and education functions.
 - (3) An EAPC to administer the ASAP civilian non-clinical assistance services.
 - (4) An IBTC to administer the biochemical testing program.
 - (5) An Installation Breath Alcohol Technician (IBAT) (in the Continental United States (CONUS), Hawaii, Alaska,

and Puerto Rico) to instruct and assist individuals in the alcohol testing process and to operate an evidential breath testing device in accordance with DOT guidelines.

(6) At the commander's discretion, Risk Reduction Coordinators may be appointed to facilitate risk reduction activities.

c. Establish a local Human Resource Council (HRC) or other appropriate human service coordination forum to focus on substance abuse prevention and risk reduction. (See para 2-4b of this regulation for information on HRC operations.)

d. Establish an Installation Prevention Team (IPT) and approve the Installation Prevention Plan (IPP) developed by the team for installation-wide implementation of substance abuse prevention and risk reduction programs and activities under this regulation.

e. Exercise direct supervision of the installation ADCO.

f. Notify the local Medical Treatment Facility (MTF) commander of any indications that ASAP clinical functions are not being provided in accordance with Army Regulations.

g. Support law enforcement and drug suppression activities by ensuring the following—

(1) Continuous command presence in installation living, working, and recreational areas to reduce alcohol and other drug abuse.

(2) Immediately report all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia to the Provost Marshal (PM) for investigation or referral to the USACIDC. This includes all (random/command directed) positive test results that do not require a medical review as directed by USAMEDCOM. Positive test results that require MRO review as directed by USAMEDCOM will not be reported until receipt of the MRO's findings and coordination with the local staff judge advocate (SJA)/legal advisor.

(3) ADCOs or their representatives are provided with the complete DA Form 3997 (Military Police Desk Blotter) on a daily basis. The ADCO will promptly furnish this information to the CD.

(4) All suspected alcohol and other drug abusers, including those in military confinement facilities, are referred to their commanders for follow-up action promptly.

h. Support positive and nonattributional approaches to risk reduction.

i. Provide an infrastructure for collaborative efforts at risk reduction on the part of human service support agencies and all levels of command at the installation.

j. Facilitate business processes and structures to support RRP.

k. Establish, support, and conduct evaluations in accordance with the AEP and MACOM supplements.

l. Evaluate IPPs annually.

1-17. Installation ADCOs

Installation ADCOs will—

a. Provide direct supervision, management, and administration over all non-clinical personnel staff and programs.

b. Prepare installation ASAP non-clinical budget submissions and monitor execution of the funding.

c. Develop, coordinate, and recommend local ASAP non-clinical policies and procedures for implementation.

d. Manage and monitor the biochemical testing program (see chap 14 for information on specific requirements related to the civilian and other drug testing.)

e. Serve as the coordinator of all substance abuse/risk reduction issues for the HRC or similar forum.

f. Monitor and evaluate the commander referral rate and the evaluation completion rate, and provide quarterly reports to the installation commander and the Director ACSAP.

g. Ensure there is a continuous and comprehensive ASAP staff training plan for all non-clinical staff to enhance professional skills.

h. Establish communication, referral network, and administrative coordination between military units and civilian activities to facilitate the effectiveness of non-clinical ASAP programs.

i. Provide commanders and supervisors with ASAP consultation to assist in the identification and referral of individuals suspected of alcohol and/or other drug abuse and in the non-clinical functions of the Army's program.

j. Maintain non-clinical ASAP, and EAP records and authenticate all non-clinical ASAP reports furnished to higher headquarters.

k. Institute procedures and strategies designed to enhance the deterrent effect of drug testing.

l. Consult with the ASAP clinical staff, local law enforcement personnel, and other installation personnel in designing and implementing the IPP.

m. Evaluate all prevention education and training aspects of the local ASAP at the end of the fiscal year and, using input from the PCs, forward through the MACOM ADCO to the Director, ASAP, a written report of the installation prevention program activities and accomplishments.

n. Restrict notification of positive test results to the soldier's unit commander, the garrison or similar level commander, and when requested, the supporting legal office.

1–18. Installation EAPCs and PCs

EAPCs will administer the ASAP employee assistance program. (See para 14–8 of this regulation for a list of program duties.) PCs will—

- a.* Promote ASAP services using marketing, networking, and consulting strategies.
- b.* Ensure all military and civilian personnel are provided prevention education services (that is, a minimum of 4 hours annually for military personnel and 3 hours for civilian employees). DOT-designated positions and other high-risk civilian positions should receive more intensive training pertaining to their jobs.
- c.* Train combat stress control medical units and division and brigade mental health sections to provide substance abuse prevention and education, and risk reduction training during deployment.
- d.* Maintain liaison and coordination with the installation-training officer to assist in integrating the preventive education and training efforts into the overall installation-training program.
- e.* Design, develop, and administer target group-oriented alcohol and other drug prevention education and training programs in coordination with the ASAP staff and other installation prevention professionals.
- f.* Maintain liaison with schools serving military family members, civic organizations, civilian agencies, and military organizations to integrate the efforts of all community preventive education resources.
- g.* Oversee the UPL training program.
- h.* Maintain lists of available continuing education and training courses and workshops provided by ACSAP, MACOMs, and appropriate civilian agencies for ASAP non-clinical staff and coordinate allocations for military and civilian training courses through the MACOM.
- i.* Address military community risk levels and work toward reducing the risk factors.

1–19. Installation IBTCs

IBTCs will—

- a.* Operate a forensically secure installation biochemical testing program control point. Serve as the installation subject matter expert on urinalysis collection and testing.
- b.* Augment the installation Inspector General inspection teams.
- c.* Ensure that unit urine collections are performed as required.
- d.* Provide technical assistance and support the UPL certification training program.
- e.* Advise unit commanders and ADCOs on program utilization and test results.
- f.* Manage expenditures and supplies.

1–20. Installation CDs

CDs will—

- a.* Administer and manage the treatment and quality assurance functions of the ASAP.
- b.* Ensure the ASAP clinical program and the physical facility meet the MTF accrediting standards in accordance with DODD 6025.13.
- c.* Provide quarterly reports, clinical data (for example, referral and evaluation completion rates, number of enrollments by alcohol and drug, and number of success/failures) to the installation ADCO who will include the data in the ASAP information routinely forwarded to the installation commander.
- d.* Inform the ADCO of issues affecting the ASAP program.
- e.* Ensure ASAP screening, evaluations, and command consultations are performed as required.
- f.* Ensure forms are completed and submitted to ACSAP in a timely manner.
- g.* Conduct in-service training, supervise the ASAP counselors and ensure the counselors maintain privileges to perform their assigned clinical responsibilities.
- h.* Appoint an ASAP clinician to serve as a member of the Family Advocacy Case Management Team.

1–21. Installation PMs

PMs will—

- a.* Screen all incident reports for possible alcohol or other drug abuse involvement and provide them to the ADCO for review and subsequent transfer of those reports to the CD and others as appropriate.
- b.* Coordinate all alcohol and other drug abuse countermeasures with the ADCO.
- c.* Support the ADCO on matters pertaining to the alcohol testing of DOT-designated positions.
- d.* Maintain liaison and coordinate alcohol and other drug abuse countermeasures with the local elements of the USACIDC and with Federal, State, and local law enforcement agencies, as well as traffic, safety, and customs agencies, and ASAP. When appropriate, include host country agencies to minimize the incidence of alcohol and other drugs as causative factors in traffic accidents and/or criminal acts.

1-22. Installation safety officers

Safety officers will coordinate with the ADCO and provide data on the incidence of alcohol and/or other drug involvement in accidents or other safety mishaps.

1-23. Installation risk reduction coordinators

Risk Reduction Coordinators will—

- a.* Coordinate and facilitate data collection, analysis, command consultation and prevention/intervention delivery approaches and systems.
- b.* Facilitate the collaborative efforts of the IPT.

1-24. Installation prevention team (IPT) members

IPT members will—

- a.* Support the data collection, analysis, command consultation and prevention/intervention efforts of the RRP.
- b.* Train incoming commanders on RRP.

1-25. Commanders of corps, division, brigade, and battalions

Commanders at these levels will—

- a.* Monitor the implementation of appropriate initiatives of the ASAP by their subordinate units.
- b.* Appoint an officer or noncommissioned officer (E-5 or above) on orders as the UPL who must be certified through required UPL training addressed in paragraph 2-6h(1) of this regulation. Recommend that a national background check be accomplished on all UPL candidates. With information provided through background check, the commander will have final decision regarding UPL's eligibility.

1-26. Commanders of companies, detachments, and equivalent units

Commanders at these levels will—

- a.* Appoint an officer or noncommissioned officer (E-5 or above) on orders as the UPL who must be certified through required UPL training addressed in paragraph 2-6h(1) of this regulation. Recommend that a national background check be accomplished on all UPL candidates. With information provided through background check, the unit commander will have final decision regarding UPL's eligibility.
- b.* Implement a unit biochemical-testing program. (See chap 8 of this regulation for guidance.)
- c.* Implement ASAP prevention and education initiatives addressed in paragraph 2-6 of this regulation. All soldiers will receive a minimum of 4 hours of alcohol and other drug awareness training per year.
- d.* Ensure all newly assigned soldiers are briefed on ASAP policies and services.
- e.* Maintain liaison with ASAP clinical and non-clinical personnel.
- f.* Maintain ASAP elements while deployed, to the maximum extent possible.
- g.* Support positive and nonattributional approaches to soldier risk reduction.
- h.* Work with the Risk Reduction Coordinator and the IPT in designing and effecting prevention and intervention approaches.
- i.* Immediately report all offenses involving illegal possession, use, sale, or trafficking in drugs or drug paraphernalia to the Provost Marshal (PM) for investigation or referral to the USACIDC. This includes all (random/command directed) positive test results that do not require a medical review as directed by USAMEDCOM. Positive test that require MRO review as directed by USAMEDCOM will not be reported until receipt of the MRO's findings and coordination with the local staff judge advocate (SJA)/legal advisor.
- j.* Assess programs and provide feedback to the Risk Reduction Coordinator and IPT for program improvements.

1-27. Unit prevention leaders (UPLs)

UPLs will—

- a.* Design, implement, and evaluate the unit prevention plan, and coordinate with the installation's PCs to integrate the unit plan into the community's substance abuse prevention plan.
- b.* Assist in briefing of all new unit personnel regarding ASAP policies and services.
- c.* Administer the unit biochemical-testing program.
- d.* Inform the commander of the status of the ASAP and of trends in alcohol and other drug abuse in the unit.
- e.* Maintain liaison with the servicing ASAP counseling center or medical unit when deployed.
- f.* Develop, coordinate, and deliver informed prevention education and training to the unit.
- g.* Develop command support for prevention activities by establishing an open, honest, and trusting relationship with the unit commanders and subordinate leaders.
- h.* Advise and assist unit leaders on all matters pertaining to ASAP.

1–28. Manpower staffing

Manpower resources for the ASAP have been provided at all levels of command. Reprogramming of manpower resources allocated for ASAP functions is not authorized.

a. Non-clinical resources: Non-clinical staffing consists of those positions listed in paragraph 1-16b of this regulation (that is, ADCO, PC, EAPC, IBTC, and IBAT) and whatever additional staff are necessary to ensure compliance with DA policies and meet local needs for effective operation of the ASAP.

b. Clinical resources: Clinical staffing consists of counselors, clinical directors, clinical consultants, medical review officers, and substance abuse professionals, and whatever additional positions are necessary to ensure compliance with DA policies and meet local needs for effective operation of the ASAP clinical program. Army Medical Department (AMEDD) or clinical personnel will not serve as ADCOs except within USAMEDCOM activities. ADCOs will not serve as CDs.

1–29. Program authority

a. On 28 September 1971, Public Law (PL) 92-129, mandated that the Secretary of Defense develop programs for the identification, treatment, and rehabilitation of alcohol or other drug dependent persons in the Armed Forces. In turn, the Secretary of Defense requires each of the Services to develop alcohol and other drug abuse prevention and control programs in accordance with DODD 1010.4. In response to this directive, the Army conducts a comprehensive program to prevent and control the abuse of alcohol and other drugs.

b. The civilian aspects of the ASAP were developed in response to PL 92-255 and PL 91-616. Additional authority for ASAP civilian services can be found in appendix A.

1–30. ASAP mission/objectives

The ASAP's mission is to strengthen the overall fitness and effectiveness of the Army's total workforce and to enhance the combat readiness of its soldiers. The following are the objectives of the ASAP:

- a.* Increase individual fitness and overall unit readiness.
- b.* Provide services, which are adequate and responsive to the needs of the total workforce and emphasize alcohol and other drug abuse deterrence, prevention, education, and treatment.
- c.* Implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers.
- d.* Restore to duty those substance-impaired soldiers who have the potential for continued military service.
- e.* Provide effective alcohol and other drug abuse prevention and education at all levels of command, and encourage commanders to provide alcohol and other drug-free leisure activities.
- f.* Ensure all military and civilian personnel assigned to ASAP staffs are appropriately trained and experienced to accomplish their mission.
- g.* Achieve maximum productivity and reduce absenteeism and attrition among DA civilian employees by reducing the effects of the abuse of alcohol and other drugs.
- h.* Improve readiness by extending services to the total Army.
- i.* Ensure quality customer service.

1–31. ASAP principles

The ASAP is a command program that emphasizes readiness and personal responsibility. The ultimate decision regarding separation or retention of abusers is the responsibility of the soldier's chain of command. The command role in the prevention, biochemical testing, early identification of problems, rehabilitation, and administrative or judicial actions is essential. Commanders will ensure that all officials and supervisors support the ASAP. Adequate publicity will be given to ASAP to ensure that military personnel, eligible civilian employees, and family members are aware of the commander's support and of the availability of information, referral, and treatment services. Proposals to provide ASAP services that deviate from procedures prescribed by this regulation must be approved by the Director, ASAP. Deviations in clinical issues require approval of USAMEDCOM. In either case, approval must be obtained before establishing alternative plans for services (as required for isolated or remote areas, or special organizational structures). The Army maintains the following principles:

- a.* Abuse of alcohol or the use of illicit drugs by both military and civilian personnel is inconsistent with Army values and the standards of performance, discipline, and readiness necessary to accomplish the Army's mission.
- b.* Unit commanders must intervene early and refer all soldiers suspected or identified as alcohol and/or drug abusers to the ASAP. The unit commander should recommend enrollment based on the soldier's potential for continued military service in terms of professional skills, behavior, and potential for advancement.
- c.* ASAP participation is mandatory for all soldiers who are command referred. Failure to attend a mandatory counseling session may constitute a violation of Article 86 of the Uniform Code of Military Justice (UCMJ).
- d.* Alcohol and/or other drug abusers, and in some cases dependent alcohol users, may be enrolled in the ASAP when such enrollment is clinically recommended.
- e.* Soldiers who fail to participate adequately in, or to respond successfully to, rehabilitation will be processed for

administrative separation and not be provided another opportunity for rehabilitation except under the most extraordinary circumstances, as determined by the CD in consultation with the unit commander.

f. Alcohol and other drug abuse will be addressed in a single program. Treatment services will generally be short-term and conducted in a manner that supports the military environment.

g. Unit commanders retain their authority to make personnel decisions such as initiation of separation from service, bar to reenlistment, extension on active duty to permit reenlistment. Unit commanders retain their authority to make mission related decisions, including field training or deployment, even though such actions may interfere with the treatment plan. Chapter 5 provide further details regarding personnel actions during ASAP enrollment. The treatment team in coordination with the commander will make clinical decisions. If the unit commander disagrees with the clinical decisions, the first Colonel in the soldier's chain of command may be requested to intercede with the MTF commander on the unit commander's behalf. In all circumstances, the MTF commander has final treatment decision authority and the soldier's chain of command has final administrative or command authority. If a unit commander believes a soldier does not have the potential for future service, the soldier will be processed for administrative separation in accordance with AR 600-8-24 or AR 635-200, as appropriate. If treatment is clinically indicated, the soldier will be provided treatment until separation.

h. Supervisors will refer any DA civilian employee who is found to abuse alcohol or other drugs, or who uses illegal drugs, to the installation EAPC for screening, short-term counseling, and referral for treatment.

i. When resources are available, ASAP treatment services will be offered to eligible DA civilian employees, military family members, family members of civilian employees, and retirees.

j. The confidential nature of treatment records of civilian employees with alcohol or other drug problems will be preserved according to applicable laws, rules, and regulations.

k. An active and aggressive biochemical testing program serves as a powerful tool and effective deterrent against alcohol and other drug abuse.

l. Prevention and education will be given the highest priority.

m. Either the EAPC or CD will bring all incidents of workplace violence involving alcohol or other drug abuse to the attention of the unit commander/supervisor, who will immediately refer the involved individuals to the ASAP for evaluation.

n. Military Police, USACIDC special agents, and other investigative personnel will not enroll in or otherwise infiltrate the ASAP treatment program for the purpose of law enforcement activities or to solicit information from soldiers enrolled in the ASAP.

1-32. ASAP eligibility criteria

a. ASAP services are authorized for personnel who are eligible to receive military medical services or eligible for medical services under the Federal Civilian Employees Occupational Health Services Program. In addition to military personnel, eligibility includes:

- (1) U.S. citizen DOD civilian employees, to include both appropriated and nonappropriated fund employees.
- (2) Foreign national employees where Status of Forces Agreements or other treaty arrangements provide for medical services.
- (3) Retired military personnel.
- (4) Family members of eligible personnel.

b. Other Service personnel under the administrative jurisdiction of an Army installation commander are subject to this regulation. When soldiers are under the administrative jurisdiction of another Service, they will comply with the alcohol and other drug program of that Service. They will also be reported through Army biostatistical channels. In some cases, elements of the Army and another Service are so located that cost effectiveness, efficiency, and combat readiness can be achieved by combining facilities. In such cases, the Service to receive the support will be responsible for initiating a local Memorandum of Understanding and/or Interservice Support Agreement. (Refer to DODI 4000.19.)

c. Members of the ARNG and USAR who are not on active duty (AD) are eligible to use ASAP services on a space/resource available basis.

1-33. Alcohol policies and controls

a. It is Army policy to maintain a workplace free from alcohol. Alcohol should not become the purpose for, or the focus of, any military social activity. At all levels alcohol will not be glamorized nor made the center of attention at any military function. (Refer to chap 7, AR 215-1 for guidance concerning use, possession, sale and transportation of alcoholic beverages on military installations.)

b. Alcohol abuse and resulting misconduct will not be condoned. Impairment due to alcohol use while on duty will not be tolerated.

c. Commanders will promote personal responsibility and informed decision making and will ensure that subordinates are educated about alcoholism, its early signs and symptoms, intervention techniques, and its debilitating effects on the

individual, families, and the Army's readiness. Leaders will integrate installation, unit, and individual alcohol prevention strategies and publicize the fact that abuse of alcohol will not be tolerated.

d. Unit commanders must identify soldiers who abuse alcohol and refer them as soon as identified for screening, prevention training, and treatment as necessary.

e. Unannounced unit inspections and fitness for duty testing for alcohol with certified alcohol testing devices, coupled with command sanctions, can:

(1) Promote military fitness, good order, and discipline.

(2) Promote safety.

(3) Increase awareness of the effects of alcohol consumption on duty performance, health, and safety.

(4) Prevent and deter alcohol abuse.

(5) Assist in the early identification and referral to the ASAP of soldiers at high risk to become chronic abusers and/or alcohol dependent.

f. Unit commanders/supervisors must confront suspected alcohol abusers, regardless of rank or grade, with the specifics of their behavior, inadequate performance, or unacceptable conduct.

g. Self-referral does not absolve an individual from accountability for alcohol related misconduct. Additionally, rehabilitation failure requires initiation of separation proceedings.

h. Successful completion of ASAP education or rehabilitation programs is required for all soldiers identified as alcohol abusers who desire to remain in the Army.

1-34. Alcohol sanctions

a. An administrative separation action will be initiated and processed to the separation authority for decision of soldiers involved in two serious incidents of alcohol related misconduct in a year, such as more than one instance of drunk on duty or operating a motor vehicle while intoxicated.

b. Military personnel on duty will not have a blood alcohol level equal to or greater than .05 grams of alcohol per 100 milliliters of blood. Any violation of this provision provides a basis for disciplinary action under the UCMJ and a basis for administrative action, to include the characterization of service at separation. Only results from certified alcohol testing devices may be used in support of disciplinary or administrative actions. (Refer to AR 190-5 for guidance related to alcohol testing.) Actions must be consistent with the "Limited Use Policy" addressed in chapter 6 of this regulation. Nothing in this regulation will be interpreted to mean that impairment does not exist if the blood alcohol level is less than 0.05 percent. To be in violation of this provision, a soldier should reasonably have known prior to becoming impaired that he/she had official military duties to perform. Commanders by order or regulation may set local alcohol limits below 0.05 percent for soldiers on duty or prohibit the use of alcohol entirely during deployments as they deem necessary for mission accomplishment and to meet local conditions.

c. Soldiers diagnosed as alcohol dependent will be detoxified and given appropriate medical treatment. Those soldiers who warrant retention based on their potential for continued military service will be offered treatment and retained. Soldiers who are to be separated will be referred to a Veterans Administration (VA) hospital or a civilian program by the ASAP clinician to continue (or to initiate) their treatment.

1-35. Illegal drugs and sanctions

The following provisions underscore the Army's policy that drug abuse will not be tolerated and that there are serious consequences for such misbehavior.

a. All soldiers, to include ARNG and USAR soldiers ordered to AD, under Title 10 U.S. Code, who are identified as drug abusers, without exception, will—

(1) Be referred to the ASAP counseling center for screening.

(a) Nondependent drug users will be enrolled in the ASAP if such enrollment is clinically recommended and the unit commander concurs.

(b) Soldiers diagnosed as drug dependent should be detoxified and given appropriate medical treatment. These soldiers generally do not have potential for continued military service and should not be retained. These soldiers will be referred to a VA hospital or a civilian program by the ASAP clinician to continue (or to initiate) their treatment.

(2) Be considered for disciplinary action under the UCMJ, as appropriate.

(3) Be processed for administrative separation in accordance with AR 600-8-24 (for officers and warrant officers) and AR 635-200 (for enlisted personnel), with the exception of self-referrals (See para 6-3e of this regulation). In cases where the chain of command has referred the matter to a trial by court-martial, administrative separation proceedings will be delayed until the completion of the court-martial process.

b. Discharge for misconduct under AR 600-8-24 (for officers and warrant officers) and AR 635-200, Chapter 14 (for enlisted) will be initiated and processed to the separation authority for all soldiers involved in illegal trafficking, distribution, possession, use, or sale of illegal drugs. Soldiers will also be considered for disciplinary action under the UCMJ, consistent with Chapter 6, of AR 600-85 and Rule for courts-martial 306, MCM. Initiation of administrative

separation proceedings is not required in those instances where charges have been referred to a court-martial empowered to adjudge a punitive discharge, or when drug use is discovered through self-referral (see para 6-3e, AR 600-85).

c. All ARNG and USAR soldiers ordered to AD will be tested for illegal drug abuse at their reception station. Those soldiers who are subsequently identified as illegal drug users will be processed according to paragraph 1-35a of this regulation.

d. Studies have shown that products made with hemp seed oil may contain varying levels of tetrahydrocannabinol (THC), an active ingredient of marijuana which is detectable under the Army Drug Testing Program. In order to ensure military readiness, the ingestion of hemp seed oil or products made with hemp seed oil is prohibited. Failure to comply with the prohibition on the ingestion of hemp seed oil or products with hemp seed oil is a violation of Article 92, UCMJ.

1-36. Law enforcement relationship to the ASAP

a. It is Army policy to encourage voluntary entry into the ASAP. Military police, USACIDC special agents, and other investigative personnel will not solicit information from clients in the program, unless they volunteer to provide information and assistance. If the client volunteers, the information will not be obtained in the CCC or in such a manner as to jeopardize the safety of sources of the information or compromise the confidentiality and credibility of the ASAP (AR 190-30 and 195-2).

b. Title 42, Code of Federal Regulations, prohibits undercover agents from enrolling or otherwise infiltrating an alcohol or other drug treatment or rehabilitation program for the purpose of law enforcement activities. This restriction does not preclude the enrollment in the ASAP, for rehabilitation purposes, of military police, USACIDC, or other investigative personnel who have an actual alcohol or other drug abuse problem. Their law enforcement status must be made known to the ADCO at the time of their enrollment. These measures are for the protection of the law enforcement client as well as the ASAP.

c. The provost marshal and the ADCO will exchange information for the purpose of identifying drug abuse trends, drug "trouble spots," and high-risk areas to include specific prevention efforts. This may include information on drug prevalence by type of drug, cost, strength and purity, and current drugs of choice. This exchange of information will be specific and will not mention names of any client or violate program confidentiality.

Chapter 2 Alcohol and Other Drug Abuse Prevention

Section I General

2-1. Definition of prevention

Alcohol and other drug abuse prevention includes all measures taken to deter and reduce the abuse or misuse of alcohol and other drugs to the lowest possible level. Prevention for readiness involves the commitment of command resources, policies, installation organizations, and community members to create and foster conditions that promote mission readiness and enhance the quality of life for the total Army.

2-2. Alcohol and other drug abuse prevention objectives

The objectives of alcohol and other drug abuse prevention are to:

- a. Prevent, deter, and reduce alcohol and other drug abuse.
- b. Provide soldiers with substance abuse prevention and awareness training to include as a minimum the following:
 - (1) ASAP policies and services.
 - (2) Consequences of alcohol and other drug abuse.
 - (3) Incompatibility of alcohol and other drug abuse with physical and mental fitness, combat readiness, and Army values.

2-3. Prevention policies

Army prevention policy maintains that:

- a. Prevention efforts will be tailored to diverse groups and integrated with other mission-related efforts.
- b. Prevention initiatives will emphasize cooperation and partnerships within the total community and encourage military involvement in local civilian community alcohol and other drug prevention efforts.
- c. Education and training programs must include information on the effects and consequences of alcohol and other

drug use. These programs must also include information describing which clinical and non-clinical services are available at the installation.

d. Alcohol deglamorization is an essential element of the Army prevention program. All members of the military community will be provided with the information needed to make responsible decisions about personal use of alcohol.

e. Commanders and supervisors must be provided with the information and skills they need to enable early identification of substance abusers.

f. Alcohol and other drug abuse education will be conducted throughout the Army Training System.

g. Alcohol and other drug abuse instruction will be compatible with the indoctrination of recruits in the standards of discipline, performance, and behavior.

h. Risk reduction and comprehensive installation-wide prevention supports readiness and will be promoted at all levels.

i. The IPP will include individual unit prevention plans, a marketing plan designed to promote the full range of services available in the community, and an identified evaluation methodology.

Section II

Prevention Strategies

2-4. Community-based processes/initiatives

a. Prevention initiatives will be community-based, emphasize military involvement, and be documented in a comprehensive IPP. This plan will promote and enhance healthy life choices; smart decision-making; soldier, civilian employee, and family member quality of life; and Army values.

b. An HRC will be established locally and will be composed of representatives of units and activities on the installation. The chairperson of the council will be a senior officer such as the chief of staff or deputy installation commander. When other uniformed Service installations are located nearby, reciprocal membership is encouraged. This council functions in an advisory capacity to the installation commander and:

(1) Provides leadership, direction, and assistance in the design and development of the IPP, which will include an continuous assessment of substance abuse and other risk factors.

(2) Approves, monitors, and makes recommendations as necessary for the implementation of the community alcohol and other drug abuse prevention and risk reduction plan.

(3) Meets on a regular basis, but no less than quarterly. Minutes of each council meeting will be approved by the commander and provided to MACOM ADCOs.

2-5. Risk reduction program (RRP)

RRP is a critical element of comprehensive installation prevention programs. It provides commanders and human resource personnel with a means of identifying and preventing high-risk problem behavior which can directly impact individual and unit combat readiness. Installation commanders should implement and maintain the RRP to obtain its readiness enhancement benefits.

2-6. Substance abuse prevention and awareness training

a. The education and training for all members of the military community is a vital element of a comprehensive community prevention plan. All soldiers will receive a minimum of 4 hours of alcohol and other drug awareness training per year. Specific education and training objectives and policies are identified in paragraphs 2-2 and 2-3 of this regulation.

b. Alcohol and other drug abuse prevention education are a vital element in leader development and will be integrated throughout the Army Training System.

c. Leadership training in substance abuse prevention and risk reduction will occur at all levels to include brigade, battalion, and company elements.

d. Substance abuse and risk reduction training will occur at initial entry, pre-commissioning, and annually thereafter.

e. Supervisory substance abuse prevention and risk reduction education and training for individuals with command and/or first-line supervisory (that is, Sergeant to Captain) responsibility will occur within 60 days after designation of supervisory/command responsibilities. Specific supervisory civilian employee education and training requirements pertaining to the Drug-free Federal Workplace Act and the DOT Alcohol and Drug Misuse Rules are addressed in chapter 14 of this regulation.

f. ASAP prevention education and training for DA civilian employees will be provided in conjunction with, but not be limited to, existing civilian personnel orientations and training programs. All civilians will receive a minimum of 3 hours of alcohol and other drug awareness training per year.

g. ASAP prevention education and training of family members addressed in the IPP will be provided on a voluntary

basis and will highlight the local laws, extent of abuse, availability of counseling, treatment services, and alternatives to alcohol and other drug abuse.

h. Specific training courses include the following.

(1) The UPL course is a standardized period of instruction designed to educate and train UPLs, through the ASAP.

(2) IPT training (IPTT) educates multidisciplinary installation teams on best prevention practices in community prevention, behavioral risk reduction, and workplace violence prevention programs. Teams develop collaborative strategies to address prevention of high-risk behaviors, learn and apply the Army's risk reduction model, and develop their IPPs. Course attendees consist of key personnel selected by the installation commander. Training is available to installations through the ACSAP.

(3) Alcohol and other drug abuse prevention training (ADAPT) is implemented through a minimum of 12 hours of instruction which focuses on the adverse effects and consequences of alcohol and other drug abuse. The approved curriculum is provided in the ADAPT Manual published by the ACSAP. Requests for exceptions to the ADAPT curriculum will be submitted in writing to the Director, ACSAP for approval. Participant follow-up is an integral part of the ADAPT program, and referral to the ASAP counseling center or other services is a viable option at any point. ADAPT training will be permitted for civilian personnel and family members on a space available basis. ADAPT training will be permitted for the following military personnel:

(a) Those referred and screened but not enrolled in the ASAP treatment program. These personnel generally have been identified as first time abusers and do not require treatment.

(b) Those referred, screened, and enrolled in the treatment program. ADAPT may be included as part of individualized treatment plans.

(c) Those referred directly by the unit commander for reasons related to poor performance, safety violations, high-risk behaviors, and disciplinary problems.

(d) Those who volunteer for the course with the permission of their unit commander.

2-7. Evaluation of prevention initiatives

a. ADCOs evaluate all ASAP non-clinical functions.

b. The ADCO, in coordination with the IPT, evaluates substance abuse prevention and risk reduction program activities as identified in the IPP annually.

2-8. Alcohol and other drug abuse control actions

a. Marketing and promotion of practices, which glamorize alcohol use are prohibited.

b. There will be no alcohol consumption during duty hours at the workplace unless specifically authorized by the first General Officer/installation commander in the chain of command.

2-9. Law enforcement and drug suppression activities

a. Comprehensive prevention programs include community law enforcement and drug suppression efforts that are designed to:

(1) Eliminate the supply of illegal drugs.

(2) Identify and apprehend individuals who illegally possess, use, or traffic in illegal drugs.

(3) Prevent alcohol and other drug related crimes, incidents, and traffic accidents.

b. USACIDC responsibilities are identified in paragraph 1-15b of this regulation.

2-10. Prevention, education, and training expenditures

The ASAP program is authorized to purchase promotional items in support of substance abuse prevention and risk reduction program campaigns. These items may be used to support local or Army-sponsored prevention campaigns such as National Drunk and Drugged Driving Prevention Month, National Red Ribbon Week, and National Alcohol Awareness Month. Promotional items purchased shall not indicate that the Army endorses a particular product or private organization.

Chapter 3

Identification, Referral, Screening, Evaluation, and the Rehabilitation Team

Command involvement throughout the identification, referral, screening, and evaluation process is critical. Commanders and the ASAP clinical staff jointly share in the rehabilitation team process, to include consultation; furnishing relevant data, information, and observations; establishing standards for behavior; and setting goals for evaluating soldiers' progress.

3-1. Identification

Early identification is a critical aspect of the ASAP intervention process. Identification occurs through:

- a. Voluntary (self-identification).*
- b. Commander/supervisor identification.*
- c. Biochemical identification.*
- d. Medical identification.*
- e. Investigation and/or apprehension.*

3-2. Voluntary (self-identification)

a. Voluntary (self-identification) is the most desirable method of identifying alcohol or other drug abuse. The individual whose performance, social conduct, interpersonal relations, or health becomes impaired because of the abuse of alcohol or other drugs has the personal obligation to seek rehabilitation. (See para 3-8 of this regulation for additional requirements.) The soldier's unit commander must become involved in the evaluation process.

b. Identification resulting from a soldier seeking emergency treatment for an actual or possible alcohol or other drug overdose, not subsequent to a traffic accident or criminal offense, is considered to be a variation of volunteering. For reporting purposes, such cases will be classified as self-referral.

c. A "Limited Use Policy" which restricts the consequences of the soldier's involvement in the ASAP is described in chapter 6 of this regulation. These provisions are unchanged by the mandatory initiation of separation processing of drug abusers, and such separation processing must comply with the provisions of limited use and AR 600-8-24 and AR 635-200.

d. A soldier may seek assistance from other agencies for problems associated with family members in which the soldier's abuse of alcohol or other drugs is a factor. Every effort will be made to ensure that those agencies (that is, military or civilian human services) are aware of the ASAP services and procedures (for example, mandatory command involvement) for referral. Such family member cases will be classified as "volunteer (self-identification)".

3-3. Commander/supervisor identification

Commander/supervisor identification occurs when a commander/supervisor observes, suspects, or otherwise becomes aware of an individual whose job performance, social conduct, interpersonal relations, physical fitness, or health appears to be affected adversely by suspected abuse of alcohol or other drugs. When abusers or suspected abusers are identified, they will be processed by their unit commander or designated representative IAW para 3-7 this regulation and referred to the ASAP counseling center for an initial screening interview.

3-4. Biochemical identification

Biochemical identification can be accomplished either by urinalysis or alcohol breath testing methods. Biochemical testing is discussed in detail in Chapter 8 of this regulation.

a. Any soldier identified as an illegal drug abuser through urinalysis will be referred to the ASAP counseling center for screening.

b. Any soldier on duty whose alcohol breath test result indicates an alcohol impairment as discussed in para 1-34 b of this regulation will be referred to the ASAP counseling center for screening.

3-5. Medical identification and investigation and/or apprehension

a. A physician or health care provider during routine or emergency medical treatment may note apparent alcohol or other drug abuse. In such instances, the physician or health care provider will refer the individual to the ASAP counseling center using a SF 513 (Medical Record-Consultation Sheet). The ASAP clinician will immediately notify the soldier's unit commander of the physician's referral.

b. A soldier's alcohol or other drug abuse may be identified through military or civilian law enforcement investigation and/or apprehension. The unit commander will refer the individual to the ASAP counseling center for an initial screening interview within 72 hours of notification of apprehension of a soldier for apparent alcohol or other drug abuse. Referral for screening or enrollment does not interfere with or preclude pending legal or administrative actions in any way.

3-6. Medical Review Officers

The MRO determines if positive drug test results reported by the toxicology laboratory could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures.

a. The MRO must be a physician, trained and certified to perform MRO functions, and appointed in writing. Physician assistants and pharmacists will not be appointed as MROs

b. When a drug test has been reported positive by the toxicology laboratory for a drug with a possible legitimate medical use as determined by USAMEDCOM, the unit commander will offer the soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the soldier's physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and

the medical reason for its use. The documentation will be marked "Confidential" and will be forwarded through the ADCO to the MRO for evaluation. Unit commanders will not initiate any unfavorable action against the soldier identified until the MRO had rendered an evaluation.

c. If the MRO is unable to make a determination without talking directly with the soldier, the unit commander will schedule an appointment to allow the soldier to meet with the MRO if practical. If not practical, the MRO will conduct the interview by telephone.

d. When the MRO has made a determination regarding the cause of the positive drug test results the unit commander will be notified promptly.

(1) If the MRO determines legitimate medical use, then no further action is required.

(2) If the MRO determines no legitimate medical use, then actions will be taken in accordance with paragraph 3-7 of this regulation.

3-7. Commander's actions for referring soldiers suspected of alcohol or drug abuse

a. When soldiers are identified as probable alcohol or other drug abusers, the unit commander or designated representative must:

(1) Coordinate with law enforcement about whether the commander or designated representative or law enforcement should conduct the initial interview of the alcohol or drug abuser.

(2) When the unit commander believes the Limited Use policy applies the unit commander should consult with the ADCO and supporting legal advisor. The unit commander may then explain the Limited Use Policy, if applicable to the particular circumstances.

(3) If the law enforcement does not initiate an investigation, advise soldiers of their rights under Article 31, UCMJ using a DA Form 3881 (Rights Warning Procedure/Waiver Certificate). If the soldier elects to remain silent or to request a lawyer, there can be no further questioning or interviewing and this procedure must terminate. Commander will then refer the soldiers the ASAP counseling center (See para b, below.)

(4) If law enforcement does not initiate an investigation, interview soldiers and inform them of the evidence.

(5) If law enforcement does not initiate an investigation, give soldiers the opportunity to provide additional evidence, including information on drug sources, if they desire. (However, such disclosure is voluntary.)

(6) If law enforcement does not initiate an investigation, collect any illegal drugs or drug paraphernalia that the soldier voluntarily relinquishes and turn these items over to the local Provost Marshall (PM) according to AR 190-22.

b. The unit commander will refer individuals suspected or identified as alcohol and/or other drug abusers, including those identified through urinalysis (except those determined legitimate medical use by the MRO) and/or blood alcohol tests, to the ASAP counseling center for screening. Soldiers impaired by alcohol as described in paragraph 1-34 b of this regulation while on duty will be referred to the ASAP counseling center for the initial screening interview. Soldiers who are referred by the unit commander for an initial interview, regardless of the means of identification, will be referred using a DA Form 8003 (Alcohol and Drug Abuse Prevention and Control Program Enrollment), contained in AR 40-66 that the commander must sign.

c. A Unit Commander's Guide to the Army Substance Abuse Program (ASAP) is contained in appendix B of this regulation.

3-8. Self referrals

The ASAP clinical staff will conduct an initial interview with all eligible personnel who self-refer to the ASAP counseling center for assistance. During the initial interview, the clinician will advise soldiers of their unit commander's role in the referral, evaluation, and treatment process, or other disposition, explain limited use policy, and provide information about ASAP services. If after the initial screening interview further services are warranted, the ASAP clinician will contact the unit commander and coordinate the soldier's formal referral using DA Form 8003, which will be signed by the unit commander and be annotated as a self referral.

3-9. Other referrals

In addition to referrals from medical or law enforcement agencies, other sources (for example, military Chaplains) may identify or refer soldiers suspected of alcohol or other drug abuse. Referrals from sources other than command, medical, investigation and/or apprehension will be handled in the same manner as a self-referral.

3-10. Screening

a. An initial interview will be conducted with all individuals who are either referred for screening or who voluntarily seek treatment. During the initial interview the ASAP clinicians will explain limited use policy. This interview will be conducted by a member of the ASAP counseling center staff within 5 duty days of the referral. Emergency referrals receive priority.

b. If after the initial interview further in-depth assessment is warranted, the ASAP clinician will advise the unit commander and initiate a comprehensive individual biopsychosocial assessment. Command input into this assessment

is essential. However, only the clinical staff may prescribe treatment. Paragraph 1-31g of this regulation discusses command and clinical responses in more detail.

c. The treatment team in coordination with the unit commander will determine clinical decisions. Clinical disagreements will be resolved jointly by a Colonel (that is, the soldiers commanders may appeal to the first Colonel in the chain of command) and the Medical Treatment Facility commander who has the final authority.

d. If a unit commander believes a soldier does not have potential for future service, the soldier will be processed for administrative separation in accordance with AR 600-8-24 or AR 635-200, as appropriate. If treatment is clinically indicated, the soldier will be provided treatment until separation.

3-11. Medical evaluation

a. The unit commander, supervisor, CD, counselor, or soldier may request a medical evaluation by a physician at any time to determine the extent of alcohol or other drug abuse. A medical evaluation is required in cases of suspected alcohol and/or drug dependence, and in all cases prior to entry into an ASAP partial inpatient care program.

b. If referral for medical evaluation is required, both a DA Form 4465 (Patient Intake/Screening Record (PIR)), and guidance for its completion is provided in DA Pam 600-85, chapter 5, and a DA Form 8003 will be completed by the ASAP clinician and provided to the physician for review prior to medical evaluation. Any other comments or recommendations made to the physician conducting the medical evaluation will be recorded on a SF 600 (Health Record-Chronological Record of Medical Care). Upon completion of medical evaluation, all forms will be returned to the ASAP counseling center for inclusion in the ASAP patient medical record. The evaluation/review of a positive drug test result by a trained MRO is not to be confused with the medical evaluation conducted by a physician to determine the severity of medical complications caused by alcohol and/or other drug abuse.

3-12. Rehabilitation team

The rehabilitation team will convene shortly after the ASAP clinical services staff has completed the individual biopsychosocial assessment and finalized the clinical summary. The purpose of the team is to review the results of the assessment/clinical summary and to develop treatment options. The team will be composed of the soldier, the unit commander and/or First Sergeant, the ASAP clinical staff, and others as appropriate. The ASAP clinician will recommend to the commander the appropriate disposition of the referral with the input of the rehabilitation team. Any of the following actions will be recommended:

- a.* Counseling by the unit commander or the commander's designated representative.
- b.* Referral to other agencies (for example, military Chaplains, marriage counselor, mental health activity, Alcoholics Anonymous, and so forth).
- c.* No ASAP services required at the present time.
- d.* Referral to ADAPT. (See para 2-6h(3) of this regulation for a description of ADAPT.)
- e.* Enrollment in ASAP rehabilitation.

Chapter 4 Soldier Rehabilitation Process

Section I Introduction

4-1. General

a. The unit commander's attitude and direct involvement are critical in the soldier's rehabilitation process. Command support must be positive and clearly visible. The commander must be aware of the soldier's immediate problems identified during the biopsychosocial assessment and is familiar with the treatment strategies and goals addressed in the treatment plan. In support of the rehabilitation process, the commander must:

- (1) Ensure that soldiers suspected of having an alcohol or other drug abuse problems are afforded an opportunity to be evaluated for treatment.
- (2) Have a full understanding of the various program elements within the ASAP.
- (3) Help soldiers cope with the environment in which they are expected to function and support soldiers' efforts to avoid relapse.

b. Rehabilitation begins with good leadership, management, and command counseling. In some instances, special

expertise is required to bring about desired changes in a soldier's performance or conduct. The commander or supervisor must:

- (1) Refer the soldier to the ASAP counseling center for screening and assistance.
- (2) Provide the ASAP clinical staff with as much information as possible regarding the soldier's behavior, involvement with alcohol and/or other drugs, and other symptoms/indicators that suggest an alcohol or other drug abuse problem.

4-2. Rehabilitation objectives

The objectives of the rehabilitation program for military personnel are to:

- a. Return soldiers to full duty as soon as possible.
- b. Identify soldiers who cannot be rehabilitated within the scope of this regulation and to advise their unit commanders.
- c. Assist and refer soldiers who cannot be rehabilitated in the ASAP to a treatment facility in the vicinity where they reside after discharge from the Army.
- d. Help resolve alcohol and other drug abuse problems in the family, with the ultimate goal of enabling the soldier to perform more effectively.

4-3. Rehabilitation elements

The ASAP rehabilitation program is comprised of four fundamental operating elements:

- a. Identification and referral.
- b. Screening/triage, comprehensive biopsychosocial assessments, and command consultation.
- c. Treatment and follow-up.
- d. For rehabilitation testing, the rehabilitation team will determine the frequency which will be included in the rehab plan.

4-4. Rehabilitation team concept

The ASAP clinician will employ the rehabilitation team concept and chair the rehabilitation team meeting, which will include the soldier, the unit commander and/or First Sergeant, the ASAP clinical staff, and others as appropriate. A record of the team's meetings, discussions, and decisions will be maintained in the ASAP patient's medical record.

Section II

Rehabilitation Procedures

4-5. Referral methods, biopsychosocial assessment, and treatment determination

- a. Soldiers may seek information anonymously. However, should an evaluation be necessary, the unit commander will be notified immediately.
- b. Referred soldiers will initially undergo a triage process to ascertain the need for immediate medical attention and further assessment. If the triage indicates a need for a more comprehensive biopsychosocial assessment, the assessment will be completed within 7 duty days.
- c. After the biopsychosocial assessment has been completed, the rehabilitation team will meet to determine what rehabilitation approach will best meet the needs of the soldier.
- d. If enrollment in the ASAP is required, the frequency, length of counseling sessions, and level of treatment will be discussed and determined by the rehabilitation team. In the event of disagreement about treatments, the MTF commander has final authority in accordance with para 1-31g of this regulation.

4-6. Rehabilitation/treatment program

The rehabilitation/treatment program is based upon the severity of the individual's involvement with substance abuse and may provide individual, group, and/or family counseling on either an outpatient or inpatient basis. Program design allows for flexibility and offers a wide variety of rehabilitation modalities structured to meet both individual needs and Army requirements for effective duty performance. Modalities are structured within the scope of individualized, short-term treatment.

4-7. Determining rehabilitation progress

- a. The unit commander, in consultation with the other members of the rehabilitation team, determines rehabilitation progress using the following factors:
 - (1) Conduct, duty performance, and relationships with co-workers.
 - (2) Further incidents of alcohol or other drug abuse.
 - (3) Motivation to overcome alcohol or other drug abuse problems.
- b. If the unit commander determines that conduct, duty performance, and progress are unsatisfactory, and that

further rehabilitation efforts cannot be justified, discharge from military service will be initiated. ASAP clinical services will be provided until the soldier is separated. Referral to VA services will be offered.

4-8. Type and frequency of treatment

- a. The type and frequency of treatment varies depending upon the individual soldier's need. It will be determined by the rehabilitation team.
- b. If relapse occurs during rehabilitation, the unit commander will be notified promptly. The rehabilitation team will then determine an appropriate course of action.
- c. Only under extraordinary conditions will the soldier be reenrolled. Reenrollment in the ASAP requires the submission of a new DA Form 4465, as the case will be treated as new for administrative reporting.

4-9. Rehabilitation/treatment appointments

Rehabilitation success is enhanced by the soldier's uninterrupted participation in the treatment plan. Consistent with mission requirements, unit commanders will ensure that the soldier's treatment plan is followed. Treatment appointments take precedence over routine duty day requirements.

4-10. Return to duty

To facilitate return to duty, the soldier's unit commander must:

- a. Assign duties commensurate with abilities, experience, and Military Occupational Specialties.
- b. Require compliance with the same standards of performance and behavior expected of other soldiers.
- c. Provide positive support.
- d. Encourage the soldier to participate in the prescribed treatment.
- e. Consult with the ASAP clinical staff during the follow-up phase of the rehabilitation.

4-11. Reassignment while enrolled in the ASAP (permanent change of station loss or gain)

a. Continuity of patient treatment is critical to successful rehabilitation. The losing CD will monitor the departure of enrolled soldiers, notify the gaining ASAP, and ensure that ASAP outpatient medical records are forwarded through the local MTF's Patient Administration Division to the gaining ASAP counseling center. If the losing ASAP counseling center is unable to determine the location of the gaining ASAP counseling center within 60 days, the losing CD will provide Army Center for Substance Abuse Program (ACSAP) with the patient identification number (that is, Social Security Account Number). ACSAP will then query the Total Army Personnel Database for assignment information and contact the gaining ASAP counseling center to verify the soldier's assignment. The gaining ASAP counseling center will notify the losing ASAP counseling center and Patient Administration Division of the soldier's assignment in the most expeditious manner and request the soldier's ASAP outpatient medical record.

b. To complete the mandatory follow-up outpatient program, patients who have received ASAP inpatient care should be stabilized in their current assignment for 12 months from the date of the inpatient enrollment. The servicing ASAP CD will provide the effective date of stabilization (date of enrollment) to the Military Personnel Office for enlisted personnel or the appropriate DA Assignment Authority for officers. In accordance with AR 614-5, table 2-2, soldiers serving in CONUS should be stabilized in their present unit assignment for 12 months from the date of inpatient enrollment, and their records should be annotated to ensure stabilization. Soldiers serving OCONUS will not be involuntarily extended beyond their established Date Eligible for Rotation Overseas to complete the mandatory follow-up outpatient program. Follow-up treatment can be obtained at the next CONUS duty station. However, unit commanders should encourage soldiers to extend their overseas tour voluntarily, under the provisions of AR 614-30, paragraph 6-2g, to receive the maximum benefit of this program. Stabilization may be terminated in accordance with AR 614-5 paragraph 2-10. Requests for early termination of the 12 month stabilization will be forwarded through USAMEDCOM (ATTN: MCHO-CL-H), 2050 Worth Road, Fort Sam Houston, TX 78234-6000 to HQDA (ATTN: PEDDA) Army Center for Substance Abuse Programs, 4501 Ford Avenue, Suite 320, Alexandria VA, 22302.

4-12. Self-help support organizations

- a. As part of the treatment plan, the soldier will be encouraged to attend and participate in Alcohol Anonymous and/or other self-help groups. Participation in a self-help organization cannot be used as the sole criterion for rehabilitation success or failure.
- b. Unit commanders and ASAP staff should become familiar with self-help organizations.
- c. Installations may facilitate the formation of self-help organizations on military installations and provide assistance as appropriate.

4-13. Transfer to VA medical facilities

- a.* Alcohol or other drug dependent soldiers may be transferred to the VA only under the following conditions:
 - (1) When within 30 days of separation.
 - (2) On the soldier's written request for transfer and additional treatment.
- b.* The request will specify the length of treatment to which the soldier agrees. No AD soldiers will be transferred to the VA through medical channels without completing the separation process. (Refer to AR 635-200.)

4-14. Unacceptable rehabilitation modalities

- a.* Methadone maintenance will not be used.
- b.* Use of Disulfiram (Antabuse) will not be mandatory.

4-15. Clinical privilege and certification requirements

Privilege and certification requirements for ASAP clinical personnel are set forth in AR 40-48 and AR 40-68.

Section III Detoxification

4-16. General

Detoxification involves the medical management of the withdrawal from alcohol or other drugs. The decision to hospitalize the soldier is a medical decision. The unit commander will maintain contact with the soldier undergoing detoxification and will participate in the detoxification effort when appropriate.

4-17. Line of duty determination

During detoxification, a line of duty determination is not required. One exception would be if a physician determined a patient to be incapacitated for a consecutive period of not more than 24 hours. In such cases, the determination will be "Not in Line of Duty Due to Own Misconduct" only for the period of actual incapacitation. (Refer to AR 600-8-1.)

4-18. Quality improvement, clinical staff competency

- a.* In accordance with applicable medical regulations, USAMEDCOM will periodically review credentials and all clinical elements of the ASAP.
- b.* CDs will assess the skills and training needs of each clinical staff member and prepare individual development plans. These plans will identify the skill needs of each member and will outline the steps planned to enhance the identified skills.

Chapter 5 Personnel Actions During Rehabilitation

5-1. General

Participation in the ASAP rehabilitation program need not interfere with normal command administrative actions.

5-2. Deployment

The unit commander in consultation with the ASAP clinical staff will determine the deployment availability of soldiers enrolled in the ASAP. The same standards used for other medical treatment will be applied. Ordinarily, soldiers:

- a.* Enrolled in the ASAP who are receiving outpatient services are deployable.
- b.* Undergoing inpatient detoxification has a temporary physical profile and is not deployable.
- c.* Participating in, or awaiting admittance to, an ASAP partial inpatient care program is deployable.

5-3. Leave policy during rehabilitation

- a.* The unit commander in consultation with the ASAP clinical staff will determine granting leave during rehabilitation.
- b.* Personnel who require detoxification during leave will be admitted to the nearest MTF. The soldier's unit commander will be notified of the circumstances that led to the curtailment of the soldier's leave or other status. After detoxification, soldiers will be returned to their unit for rehabilitation.

5-4. Suspension from duty

- a.* The unit commander may suspend soldiers from duties requiring special alertness and may also temporarily deny a soldier access to classified information. Army Regulation 380-67 and/or the supporting Security Office provide

guidelines on suspending a soldier's access to classified information and reporting the suspension to the U.S. Army Central Personnel Security Clearance Facility.

b. Additional personnel policies and procedures for soldiers in sensitive security positions, in safety sensitive aviation positions, and for soldiers enrolled in the Army's Personnel Reliability Program (PRP) are contained in Chapter 7 of this regulation.

5-5. Separation actions for alcohol and other drug abuse

When a unit commander, in consultation with the ASAP clinical staff, determines that rehabilitative measures are not practical and that separation action will be initiated, the following procedures are required:

a. All soldiers identified as illegally abusing drugs will be processed for administrative separation in accordance with AR 600-8-24 or AR 635-200.

b. Soldiers diagnosed as being drug dependent by a physician will be detoxified and then processed for administrative separation in accordance with AR 600-8-24 or AR 635-200, and be considered for disciplinary action under the UCMJ. These individuals should be referred to VA medical facilities under the conditions listed in paragraph 4-13 of this regulation.

c. Soldiers who are rehabilitation failures will be processed for administrative separation when:

(1) The member is enrolled in the ASAP.

(2) The unit commander determines that further rehabilitation efforts are not practical (that is, a rehabilitation failure).

d. When not precluded by the "Limited Use Policy" (See sec III, chap 6 of this regulation), offenses of alcohol or other drug abuse may properly be the basis for discharge proceedings under AR 600-8-24 or AR 635-200. The evidentiary aspect of the "Limited Use Policy" is applicable to discharges under AR 600-8-24 or AR 635-200. Soldiers processed for separation under other provisions of that regulation, who also are or become subject to separation under this chapter and whose proceedings on other grounds ultimately result in their retention in the service, will be considered for separation under this chapter.

e. When the unit commander determines that a soldier who has never been enrolled in the ASAP lacks the potential for further useful service, the soldier will be screened in accordance with this regulation. If found nondependent, the soldier will be considered for separation under the appropriate provisions of AR 600-8-24 or AR 635-200.

f. Individuals identified for separation in accordance with guidance contained in paragraph 5-5 will be reported to USA Central Personnel Security Clearance Facility in accordance with AR 380-67.

5-6. Reenlistment during enrollment in the ASAP

Soldiers currently enrolled in the ASAP rehabilitation program are not allowed to reenlist. However, soldiers who need additional service time to complete their enrollment may be extended for the number of months necessary to permit completion. (Refer to AR 601-280.) A waiver is not required when a soldier has successfully completed the ASAP rehabilitation program as indicated on the DA Form 4466 (Patient Progress Report (PPR)).

5-7. Suspension of favorable actions

Soldiers who are command referred to the ASAP and enrolled in the program will be flagged. (This provision will be effective when AR 600-8-2 is changed to reflect this provision).

Chapter 6

Legal Aspects, Limited Use Policy, and Confidentiality

Section I

Introduction

6-1. Overview

This chapter applies to soldiers only. See chapter 14 of this regulation for issues involving civilians. This chapter addresses collection criteria and the legal aspects for biochemical testing, "Limited Use Policy," specialized rules for administrative separation actions in ASAP cases, and confidentiality issues. It is essential that legal procedures and protection be understood by all Army personnel.

6-2. Biochemical testing

a. Biochemical testing refers to the identification of alcohol or other drug abuse through the testing of blood, urine, breath, or other bodily substance as approved by the DCSPER. The seizure of bodily substances is based on the

Military Rules of Evidence (MRE) which are summarized in Chapter 8 of this regulation. AR 600-85 does not apply forensic testing by USACID or other non-DCSPER authorized entities.

b. For specific questions concerning the collection of specimens and the application of the MRE, commanders should seek the advice of their supporting SJA.

Section II

Limited Use Policy

6-3. Objective

The objective of the "Limited Use Policy" is to facilitate the identification of alcohol and other drug abusers by encouraging identification through self-referral. In addition, the policy is designed to facilitate the treatment and rehabilitation of those abusers who demonstrate the potential for rehabilitation and retention. When applied properly, the "Limited Use Policy" does not conflict with the Army's mission or standards of discipline. It is not intended to protect a member who is attempting to avoid disciplinary or adverse administrative action.

6-4. Definition of "Limited Use Policy"

a. Unless waived under the circumstances listed in paragraph 6-3d of this regulation, limited use prohibits the use by the government of protected evidence against a soldier in actions under the UCMJ or on the issue of characterization of service in administrative proceedings. Additionally, the policy limits the characterization of discharge to "Honorable" if protective evidence is used. Protected evidence under this policy is limited to:

(1) Results of a command-directed biochemical testing that is inadmissible under the Military Rules of Evidence. Commanders are encouraged to utilize biochemical testing when there is a reasonable suspicion that a soldier is using a controlled substance or has a blood alcohol level of .05 percent or above while on duty. This information will assist a commander in his determination of the need for counseling, rehabilitation, or medical treatment. Competence for duty tests may be directed if, for example a soldier exhibits aberrant, bizarre, or uncharacteristic behavior, but probable cause to believe the soldier has violated the UCMJ through the abuse of alcohol or drugs is absent. Competence for duty test results may be used as a basis for administrative action to include separation, but shall not be used as basis for an action under the UCMJ or be considered in the issue of characterization of service.

(2) Results of a biochemical test collected solely as part of a limited use safety mishap investigation undertaken for accident analysis and the development of countermeasures, is further described in subparagraph 8-3.

(3) Information, concerning drug or alcohol abuse or possession of drugs incidental to personal use, including the results of a biochemical test, collected as a result of a soldier's emergency medical care solely for an actual or possible alcohol or other drug overdose. To qualify for limited use protection, soldiers must inform their unit commander of the facts and circumstances concerning the actual or possible overdose. The commander must receive this information as soon after receipt of the emergency treatment as is reasonably possible. If treatment takes place at a civilian facility, the soldier must give written consent to the treating civilian physician or facility for release of information to the soldier's unit commander concerning the emergency treatment rendered. If the medical treatment resulted from an apprehension by military or civilian law enforcement authorities, or if the admission for treatment resulted from other than abuse of alcohol or drugs, such as for injuries resulting from a traffic accident, the limited use protection will not be available to the soldier.

(4) A soldier's self referral to the ASAP.

(5) Admissions and other information concerning alcohol or other drug abuse or possession of drugs incidental to personal use occurring prior to the date of initial referral to the ASAP and provided by soldiers as part of their initial entry into the ASAP. This includes an enrolled soldier's admission to a physician or ASAP counselor concerning alcohol or other drug abuse incidental to personal use occurring prior to the initial date of referral to the ASAP.

(6) Biochemical test results, if the soldier voluntarily submits to a DOD or Army treatment program before the soldier has received an order to submit for a lawful biochemical test. Voluntary submission includes soldiers communicating to a member of their chain of command that they desire to be entered into a treatment program. This limited use protection will not apply to test results, which indicate alcohol or other drug abuse occurring after the voluntary submission to the treatment program. Examples: The unit commander has ordered a urinalysis test on Monday for all members of the unit (an inspection under MRE 313). Before receiving an order (or having knowledge of a pending test) to appear for the urinalysis, a soldier approaches the platoon sergeant, admits having used illegal drugs over the weekend, and indicates a desire to receive help. Later that day, the soldier provides a sample for the urinalysis, which results in a positive report for Cocaine use. Those results are protected by the "limited use policy" unless there is some evidence that demonstrates the use reflected by the test occurred after the admission was made to the platoon sergeant. Later that week, the commander orders another unit inspection for the following Monday. The inspection is conducted properly under MRE 313, and the soldier once again has a positive result for Cocaine. These test results, as interpreted

by an Army FDTL expert, indicate the soldier had used Cocaine after admitting use to the platoon sergeant. This test result is not protected by limited use.

(7) The results of a biochemical test administered solely as a required part of a DOD or Army rehabilitation or treatment program.

b. The "Limited Use Policy" does not prevent a counselor from revealing, to the commander or appropriate authority or others having a need to know, knowledge of certain illegal acts which may compromise or have an adverse impact on mission, national security, or the health and welfare of others. The unit commander will report the information to the appropriate authority. Likewise, information that the client presently possesses illegal drugs or that the client committed an offense while under the influence of alcohol or illegal drugs, other than prior illegal possession incident to the prior use, is not covered under this policy. Limited use is automatic. It is not granted, and it cannot be vacated or withdrawn. It may be waived in the situations described in paragraph 6-3e of this regulation.

c. An order from competent authority to submit to urinalysis or breath test is a lawful order. Failure to obey such orders may be the subject of appropriate disciplinary action under the UCMJ.

d. The "Limited Use Policy" does not preclude the following:

(1) The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) first has been introduced by the soldier. This rebuttal or impeachment may include evidence that test data indicate the presence of a controlled substance or alcohol, although not in sufficient quantity to meet the cutoff level for a positive result that has been established by DOD.

(2) The initiation of disciplinary or other action based on independently derived evidence, including evidence of continued drug abuse after initial entry into the ASAP.

e. If the command is made aware of a soldier's illegal drug use through the soldier's self-referral and admissions, the requirement to initiate separation proceedings pursuant to AR 600-8-24 or AR 635-200 will not apply. The unit commander may initiate a separation action; however, the information is protected by the "Limited Use Policy".

6-5. Implementation of limited use

a. Unit commanders will explain the "Limited Use Policy" to soldiers during the commander's interview as set forth in paragraph 3-7 of this regulation. Commanders will not make any agreement, or compromise, or expand the "Limited Use Policy" in any way.

b. One or more military associates of an actual or possible alcohol or drug overdose victim might be reluctant to assist the victim in obtaining emergency treatment from an MTF because they themselves are abusers of alcohol or other drugs. An assisting person may fear that adverse personal consequences could result from becoming involved. Although limited use protection is not extended automatically to such a person, the availability of the following options to those soldiers and their commanders should reduce reluctance to assist the victim:

(1) Soldiers may seek help for their own alcohol or other drug problem from:

(a) Their unit commander.

(b) The physician at the MTF.

(c) Any other agency or individual described in chapter 3 of this regulation.

(2) If the unit commander suspects a soldier of alcohol or other drug abuse, or possession of drugs incidental to personal use, solely because of a soldier's assistance to an actual or possible alcohol or drug overdose victim, and there is no reason to believe the soldier provided illegal drugs to the victim, the commander should consult with the supporting legal office and thereafter may:

(a) Inform the soldier of these suspicions.

(b) Ensure the soldier is aware of the treatment services available and the "Limited Use Policy."

(3) If the soldier admits to alcohol or other drug abuse and volunteers for help, limited use becomes effective as of the time the soldier asks for help.

c. Soldiers will receive an "Honorable" discharge regardless of their overall performance of duty, if discharge is based on a proceeding where the Government initially introduces limited use evidence except as authorized in paragraph 6-3d(1) of this regulation. The "Government" includes the following:

(1) The unit commander or intermediate commanders (in a recommendation for discharge or in documents forwarded with such a recommendation).

(2) Any member of the board of officers or an administrative separation board adjudicating the case.

(3) The investigating officer or recorder presenting the case before the board.

(4) The separation authority.

d. Alternatively, if limited use evidence is improperly introduced by the Government before the board convenes, the elimination proceeding may be reinitiated, excluding all reference to the evidence protected by the "Limited Use Policy". If the limited use evidence is improperly introduced by the Government after the board convenes, only a general court-martial convening authority may set aside the board proceeding and refer the case to a new board for

rehearing. The normal rules governing rehearings and permissible actions thereafter will apply in accordance with AR 600-8-24 or AR 635-200, as appropriate.

e. All situations, which could arise in applying the “Limited Use Policy” in the field, cannot be foreseen. As in other instances in which regulatory guidance is applied to an actual case, the commander should seek advice from the supporting legal office.

6–6. Separation actions

Illegal drug use is grounds for disciplinary action under the UCMJ and/or the initiation of administrative separation proceedings. In addition to the rules for administrative separation actions and boards (Refer to AR 600-8-24 and AR 635-200), the following rules apply to administrative separation actions and boards for illegal drug abuse. In this regard the following should be considered:

a. Biochemical test results from an Army FTDTL normally can be substantiated by a “Litigation Package” alone (See para 8-5b of this regulation). Counsel for the respondent will be allowed adequate opportunity to interview laboratory officials before the board date.

b. A respondent’s request for production of an expert witness should not be approved automatically. As with any other witness’s request, the burden is on the requesting party to demonstrate the relevance of the witnesses’ testimony. Even when relevance has been established, alternative forms of testimony, to include telephonic testimony, may be an adequate substitute to a personal appearance.

Section III

Military Confidentiality

6–7. Confidentiality of military patient ASAP information within the Armed Forces

a. The ASAP rehabilitation process generally involves the soldier, the unit commander and/or First Sergeant, the ASAP clinical staff, and others as appropriate. Generally, there is no reason for anyone other than these individuals to learn of a soldier’s alcohol or other drug abuse problem. While commanders above the unit level may on rare occasions have an official need to know the specific identity of an enrolled abuser within their commands, their knowledge of the number of abusers enrolled in the ASAP is usually sufficient information. No lists of soldiers enrolled in the ASAP will be circulated to commanders above unit level. The garrison commander must be provided the names and units of soldiers in accordance with paragraph 1-17n, but this does not include personal identification information pertaining to soldiers already enrolled in the program.

b. ASAP patient records are medical records and are protected by the restrictions contained in The Privacy Act (5 USC 552a), 42 CFR Sub Chapter A Part 2, AR 40-66, and AR 340-21. These records will be maintained by the ASAP clinical staff and stored for a period of 5 years after case closure in accordance with the Modern Army Records Keeping System and the MTF accrediting body.

c. Commanders, Inspector General personnel, Audit Agency, Security investigators, and other DOD personnel do not have unlimited access to review a soldier’s medical records. The release and/or discussion of information within the Armed Forces concerning a soldier’s abuse of alcohol and other drugs will be made known to those individuals within the Armed Forces who have an official need to know as set forth in 42 CFR, Subchapter A Part 2. This is provided they document their need to know and submit their written request to the responsible MEDCEN/MEDDAC commander for pertinent release of information as outlined in AR 40-66 regarding patient medical records.

d. On occasion, commanders (other than the soldier’s unit commander) may request seemingly confidential information regarding a specific soldier’s referral, enrollment, and participation in the ASAP rehabilitation. Such requesters will be informed that the MTF’s Patient Administration Division determines whether data can be released and will advise requesters to document their need to know and to submit their requests to the responsible MEDCEN/MEDDAC commander for the proper release of information.

e. The ASAP clinical staff will ensure that all potential disqualifying information obtained from the soldier during ASAP clinical screening and/or treatment will be promptly forwarded to the soldier’s unit commander. The ASAP clinical staff should become familiar with the provisions of AR 50-5, AR 50-6, AR 380-67, and their responsibilities regarding the PRP and the Personnel Security Program.

6–8. Confidentiality of military client ASAP information outside the Armed Forces

a. The restrictions on disclosure of confidential information allowed by the Freedom of Information Act (5 USC 522) or 5 USC 552a apply to the following:

(1) Requests for information from sources outside the Armed Forces pertaining to soldiers' participation in the ASAP.

(2) All requests for information pertaining to civilian employees' and family members' participation in the ASAP.

b. The primary intentions of the referenced policies are to:

(1) Remove any fear of public disclosure of past or present abuse.

(2) Encourage participation in a treatment and rehabilitation program.

6–9. Authority

a. PL 92-255, Section 408, the Drug Abuse Office and Treatment Act of 1972 (21 USC 1175), as amended by section 303 of PL 93-282 (88 Stat 137).

b. PL 91-616, Section 333, as amended by section 122(a) of PL 93-23 (88 Stat 131).

c. Title 42 CFR.

6–10. Penalties

The provisions of this section apply to individuals responsible for any client/patient record and to individuals who have knowledge of the information contained in client/patient records. Such records include those maintained in connection with alcohol or other drug abuse education, training, treatment, rehabilitation, or research. The criminal penalties for unauthorized disclosure of information protected by the Federal statute and regulations may include a fine of up to \$5,000 for each offense.

Section IV

Releasing ASAP Information to the Media

6–11. Releasing information to news media

a. This section provides guidance for the release to the news media of program information that does not identify any individual, directly or indirectly, as either an abuser or non-abuser of alcohol or other drugs. This includes information concerning a former abuser of alcohol or other drugs.

b. Release of information pertaining to DOD activities is the function of the Office of the Assistant Secretary of Defense (Public Affairs). The Office of the Chief of Public Affairs, HQDA, coordinates, plans, and monitors the execution of appropriate Army information activities.

6–12. Guidelines for releasing information

a. Unclassified factual information on the following may be provided to the news media in response to queries about:

(1) The Army's alcohol and other drug abuse program issues.

(2) The Army's alcohol and other drug abuse prevention and rehabilitation program as described in this regulation.

b. Tours of facilities and discussions with ASAP staff personnel must have the prior approval of the installation commander and, if appropriate, the MEDCEN/MEDDAC commander. Such tours or discussions will not be conducted at a time or location that could result in the identification of a patient as an alcohol or other drug abuser.

c. Information on quantitative results for the urine testing program and overall ASAP statistics will not be given until released by the Director, ASAP.

d. MACOMs will ensure that command information materials receive wide distribution and will respond to queries as provided in paragraphs 6-11a of this regulation.

6–13. Administration

a. Public Affairs officers may communicate directly with the Office of the Chief of Public Affairs, HQDA.

b. Requests for authority to release additional information will be directed to HQDA (ATTN: SAPA-PCD), 1500 Pentagon, Washington, DC 20310-1500.

Chapter 7

Special Provisions for Military Personnel in Critical Safety or Security Positions

7–1. General

Alcohol and other drug abuse by soldiers in critical safety or security positions is of special concern because of their adverse impacts on readiness, public health and safety, operations, life and property, and the possible disclosure of

national security information. To minimize safety and security risks, special provisions have been developed which allow:

- a. Release of potentially disqualifying information obtained from the soldier during the ASAP clinical screening and treatment.
- b. Suspension and/or revocation of a soldier's access to classified material, chemical agents, or nuclear agents.
- c. Restriction or suspension of aviation duties.
- d. Notification to the U.S. Army Central Personnel Security Clearance Facility.
- e. Increased frequency of random drug testing.

7-2. Personnel in sensitive security positions

Participation in the ASAP rehabilitation program is not in itself sufficient cause to identify a soldier as a security risk in accordance with AR 380-67. However, circumstances of a given case may warrant suspension of an individual's access to classified material. (Refer to AR 380-67 and/or the supporting Security Office for guidelines on suspending access to classified information and/or reporting information to the U.S. Army Central Personnel Security Clearance Facility.)

7-3. Personnel reliability program (PRP)

The Chemical Surety Personnel Reliability Program and the Nuclear Surety Personnel Reliability Program are command programs designed to ensure that only those soldiers who comply with the highest possible standards of reliability are allowed to perform duties associated with chemical or nuclear agents. Such reliability is maintained through the initial and continual evaluation of soldiers assigned to PRP duties. No one is assigned to a PRP position until screened and certified by the certifying official. The failure of an individual to be certified for assignment to PRP duties does not necessarily reflect unfavorably on the individual's suitability for assignment to other duties. The decision to remove or disqualify a soldier enrolled in the PRP is a command decision. ASAP policies are designed to fully support the Chemical Surety Personnel Reliability Program and the Nuclear Surety Personnel Reliability Program. (Refer to AR 50-5 and AR 50-6.)

7-4. Reporting disqualifying information

The ASAP CD must ensure that potentially disqualifying information related to the soldier's participation in ASAP counseling center screening and evaluation and the soldier's subsequent enrollment in rehabilitation will be made available to the PRP certifying official for consideration promptly. ASAP clinical personnel should be familiar with their PRP responsibilities identified in AR 50-5 and AR 50-6.

7-5. PRP urinalysis testing requirements

- a. Before PRP certification, all soldiers must submit to a urinalysis screen for illegal drug use.
- b. Certified military personnel performing PRP duties will be tested a minimum of once in a 12-month period.

7-6. Aviation personnel and alcohol and drug abuse

a. Alcohol and other drug abuse by aviation personnel are a special concern because of its impact on aviation safety and mission. Therefore, aviation personnel on flight status are required to submit to urinalysis testing annually. Aviation specialties for officers, warrant officers, and enlisted are:

- (1) Officer personnel in the 15 series and 67J specialties.
- (2) Warrant officer personnel in the 150-155 specialties.
- (3) Enlisted personnel in the 67, 68, and 93 series Military Occupational Specialties.
- (4) Flight medics, door gunners, or others who are "special details" into the aviation mission.

b. Army Regulation 40-501 provides medical fitness standards. Army Regulation 600-105 provides policies and procedures for restricting, suspending, and terminating medically unfit personnel from aviation duties and includes guidance for reinstating rehabilitated abusers determined fit to return to aviation duties.

c. For the purposes of this regulation, aviation personnel given a diagnosis of alcohol abuse or dependency by medical authority will be considered medically unfit for aviation duty. A medical waiver returning Active Component and USAR aviators to aviation duties may be obtained from the Commander, U.S. Total Army Personnel Command (PERSCOM) (ATTN: TAPC-PLP-A), 200 Stovall Street, Alexandria, VA 22332-0406. To obtain a waiver, the aviator must:

- (1) Have been totally abstinent from the use of alcohol for a minimum of 90 days.
- (2) Have completed the ASAP or joint service equivalent successfully, or be satisfactorily progressing in treatment and be actively participating (that is, weekly) in an ongoing, sobriety/self-help program.
- (3) Obtain favorable written evaluations and recommendations from the ASAP clinician or joint service equivalent, unit flight surgeon, and aviation unit commander, with endorsement by a General Officer in the chain of command, and

submit all documentation to the Commander, U.S. Army Aeromedical Center (USAAMC), Fort Rucker, AL 36362-5000 for aeromedical board review.

(4) Obtain favorable written recommendation that the aviator be allowed to return to aviation duty from the Commander, USAAMC, who will forward all documentation to Commander, PERSCOM (ATTN TAPC-PLP-A), 200 Stovall Street, Alexandria, VA 22332-0406.

(5) The Commander, PERSCOM will grant or deny the request for waiver. Generally, waiver requests, which are received at PERSCOM prior to the normal anticipated 12-month grounding period, will be evaluated on the strength of the recommendations and endorsements. The aviator's waiver must be medically reviewed by a flight surgeon each year in concert with an annual flight physical.

d. Nondependent alcohol abusers do not necessarily have to be restricted from flying duties provided their abuse of alcohol has not interfered with their performance of duty. In such cases, commanders, in coordination with the CD and the flight surgeon, will determine appropriate action regarding aviation service or flying status, under guidance in paragraph 7-6b of this regulation.

e. Aviation personnel who use illegal drugs, whether or not determined by aviation medical authorities to be medically fit, are subject to disqualification from flying duties in addition to appropriate disciplinary and administrative actions.

f. Aviation personnel, including air traffic controllers, who hold Federal Aviation Administration (FAA) medical certificates must comply with FAA standards on alcohol and other drug use.

Chapter 8

Biochemical Testing

8-1. Objectives

The objectives of Army's Biochemical Testing Program are to:

a. Deter soldiers, including those members on initial entry on AD after enlistment or appointment, from abusing drugs (including illegal drugs, other illicit substances, and prescribed medication).

b. Facilitate early identification of alcohol and/or other drug abuse.

c. Enable commanders to assess the security, military fitness, good order and discipline of their units, and to use information obtained to take appropriate action (for example, UCMJ, administrative, or other actions, including referral to the ASAP counseling center for screening, evaluation, and possible treatment).

d. Monitor rehabilitation of those enrolled for alcohol and/or other drug abuse.

e. Collect data on the prevalence of alcohol and/or other drug abuse within the Army.

8-2. Policy

a. The minimum rate of testing is one random sample per AD soldier per year. To the maximum extent possible, USAR and ARNG test rates will mirror the AD rate.

b. All urine specimen collections will be conducted in accordance with procedures set forth in appendix E. Appendix E does not apply to civilians.

c. All urine specimens will be forwarded to the supporting FTDTL.

d. Illicit use of anabolic steroids by military members is recognized as an offense under the UCMJ.

e. All confirmed positive drug tests for a drug with possible legitimate medical use as determined by USAMED-COM must be reviewed and evaluated by a MRO before any action is taken against a soldier, and prior to suspending access to classified information or reporting to the Central Clearance Facility (CCF).

8-3. Biochemical testing programs

The decision to test and how to organize the testing event is made by the commander; however commanders must be cognizant that an unpredictable testing pattern will produce a more accurate indicator of drug abuse within a particular unit than one which is predictable (whether predictability is due to an established testing pattern or due to obvious preparatory arrangements). Commanders should consider testing during non-traditional times. To realize the objectives of the Army's Biochemical Testing Program, there are eight circumstances for urinalysis testing of soldiers, each of which conform to DODD 1010.1:

a. Inspection. An inspection is an examination of a unit, or part thereof, conducted as a function of command, the primary purpose of which is to ensure the security, military fitness, or good order and discipline of the unit, and is conducted pursuant to MRE 313.

b. Search or Seizure/Probable Cause. This may include searches based on probable cause (in accordance with MRE 315) or those conducted pursuant to a recognized exception to the probable cause requirement.

c. Competence for Duty. During evaluation of a soldier, the appropriate command authority may direct urinalysis testing to determine the soldier's competence for duty or need for counseling, rehabilitation, or other medical treatment

when the commander has reason to question the soldier's competence for duty based on aberrant, bizarre, or uncharacteristic behavior, breaches of discipline, or other similar behavior. This test may be based on less than probable cause.

d. Rehabilitation. Production of a sample will be required as a part of the alcohol or other drug rehabilitation program. The rehabilitation team will determine the frequency, which will then be included in the rehab plan.

e. Mishap or Safety Inspection. Following any incident that may be considered a safety mishap; a specimen may be collected from any individual directly or indirectly involved. Samples which are collected in compliance with MRE (for example, inspection by command policy, search, seizure, or consent) may be used for any lawful purpose. However, samples may also be collected for mishap investigatory purposes only and may not satisfy the requirements of the MRE for admissibility in a court-martial. If samples do not satisfy the standards of admissibility, these tests will be protected by the "limited use policy".

f. Consent. A specimen may be provided voluntarily by a soldier as part of a consent search conducted in accordance with MRE 314(e).

g. New Entrant. Urinalysis testing may be required during the precession physical or initial period of military service. (Refer to DODI 1010.16 for a description of the policy on precession or new entrant drug testing and dependency evaluation.)

h. Medical. A specimen may be required during any examination for a valid medical purpose (for example, emergency treatment, periodic physical examinations, and such other medical examinations as are necessary for diagnostic or treatment purposes in accordance with MRE 312).

8-4. Retesting of positive FTDTL specimens

a. Positive FTDTL urine specimens may be retested, provided a sufficient quantity of the specimen is available for retesting. All requests for a retest will be in writing. Retesting will be initiated upon:

- (1) Request of the submitting installation/command, the MRO, the soldier, or an attorney representing the soldier.
- (2) Request of an administrative board under rules applicable to the board.
- (3) An order of a court-martial or rules applicable to the court-martial.

b. A soldier whose urine has tested positive for illegal drugs may obtain a retest at a commercial laboratory (NIDA approved) outside the DOD laboratory system at the individual's expense when a sufficient quantity of the same specimen is available for retesting. Only an aliquot of approximately 5-10 milliliters will be released for such testing. The original specimen and bottle shall be maintained at the laboratory or contract laboratory. The specimen must be forwarded using the chain of custody procedure and by a method that ensures the Government is not obligated to pay for testing.

c. Soldiers' requests are to be submitted through the installation/command to the laboratory performing the initial test.

8-5. Requesting urinalysis documents

a. FTDTL or contract laboratory documents pertaining to positive urinalysis results used in connection with adverse administrative or disciplinary action may be obtained by written request. All requests must identify the documents requested and must be submitted through the installation/command to the laboratory that performed the urinalysis. Requests for documents for civilian tests must be forwarded through the MRO to the installation ADCO. Documents will be furnished at no expense upon:

- (1) Request of the installation or unit commander, a SJA office, the tested individual, or the tested individual's attorney.
- (2) Request by the President or Recorder of an administrative board.
- (3) An order of a court-martial or rules applicable to the court-martial.

b. Documents which may be obtained from the FTDTL are a "Commander's Packet" (which includes items (1), (2), and (6) below) or a "Litigation Packet" (which includes items (1) through (6) below). Other documents should be requested through normal military legal channels.

- (1) An affidavit cover sheet certifying the test procedures used and results found for the soldier's specimen.
- (2) Photocopy of the installation chain of custody documents with certified results.
- (3) Photocopy of the intralaboratory chain of custody documents.
- (4) A description of the analytical methodology.
- (5) Results of the analysis of the soldier's sample.
- (6) Laboratory DOD certification.

c. The provisions of this paragraph are not intended to, and do not, provide any rights or privileges as to the relevancy or admissibility of laboratory documents that are not otherwise afforded by the UCMJ, the Manual for Courts-Martial, or regulations governing adverse administrative and disciplinary actions. In no case will failure to

comply with the provisions of this paragraph be used to invalidate an otherwise valid and legally sufficient adverse administrative or disciplinary action.

Chapter 9

Management Information System

9-1. General

The Drug and Alcohol Management Information System-Headquarters (DAMIS-HQ) provides essential management information on ASAP at each level of command. The data generated by the DAMIS-HQ provides the capability to:

- a.* Measure the magnitude of alcohol and other drug abuse.
- b.* Measure the progress made in the ASAP prevention and risk education efforts.
- c.* Measure the progress made in the rehabilitative and medical treatment aspects of the ASAP.
- d.* Identify statistical trends to support requisite policy and procedural changes.
- e.* Identify funding and manpower requirements for the ASAP.
- f.* Reply to public, media, congressional, or other Government agency inquiries.

9-2. ASAP reporting procedures

The data contained in the DAMIS-HQ originates from the reports supplied by installation ASAPs worldwide: DA Form 3711 (Army Substance Abuse Program and Performance Review (RAPR)), DA Form 4465 (Patient Intake /Screening Record (PIR)) and DA Form 4466 (Patient Progress Report). These reports are submitted by hardcopy or electronic interface through the Drug and Alcohol Management Information System-Field System (DAMIS-FS). All these forms and guidance for their completion are provided in chapter 5, DA Pam 600-85.

9-3. USAMEDCOM reporting requirements

a. At a minimum, by the 10th of each month USAMEDCOM will provide the following data to the Director, ACSAP for the previous month's operations of each FTDTL:

- (1) Total specimens received.
- (2) Total specimens tested by drug type.
- (3) Total specimens confirmed positive.
- (4) Total specimens confirmed positive by drug.
- (5) Total soldiers confirmed positive.
- (6) Total specimens with discrepancies that caused the sample not be tested, by discrepancy category.
- (7) (1) through (6) above by installation.
- (8) (1) through (7) above by MACOM.
- (9) (1) through (8) above on total fiscal year to date basis.

b. Notify the Director, ACSAP, and the installation ADCO immediately regarding any false positive results reported by the FTDTLs.

9-4. Department of Transportation (DOT) reporting requirements

a. Each Army installation shall prepare and maintain an annual calendar year summary of the results of its alcohol and other drug testing programs. The information required is found in 49 CFR Section 382.403.

b. Each installation ADCO or EAPC will ensure that a FHWA MCS-154, Rev. 1-94 (Federal Highway Administration (FHWA) Drug and Alcohol Testing Management Information System Data Collection Form) or the FHWA MCS-155, Rev. 1-94 (FHWA Drug and Alcohol Testing Management Information System "EZ" Data Collection Form) is completed not later than 15 February of each year. These forms can be obtained from the U.S. Printing Office, Superintendent of Forms, Washington, DC 20401. Test data are to be maintained for at least 5 years. Installations will promptly forward completed data forms to one of the following:

- (1) Their MSC HQs which will summarize the data and forward information to their MACOM.
- (2) Directly to their MACOM EAPAs.

c. MACOM EAPAs will ensure that a MACOM summary report and attached installation reports arrive at the ACSAP not later than 1 March of that year. The Director, ACSAP will summarize and analyze the MACOM data and forward a completed report to the DHR and to Office of the Secretary of Transportation, Drug Enforcement and Program Compliance, Room 9404, 400 Seventh Street SW, Washington, DC 20590.

9-5. ASAP patient medical records

ASAP patient records, excluding DA Forms 4465 and DA Forms 4466, are medical records governed by AR 40-66 and will consist of official forms referred to in AR 40-66. Progress notes will be recorded only on SF 600 or in an authorized database serving that purpose. No other official forms will be created without MTF approval. Clinical

correspondence and reports from outside agencies will be maintained in the ASAP patient records. Every document contained in the medical record will comply with the requirements of 5 USC 522a and the requirements of 42 USC 290dd-2.

9-6. ASAP patient medical record filing procedures

a. ASAP patient medical records will be maintained in one of the following categories:

(1) Open patient medical case records will include patients seen on a regularly scheduled basis as well as patients in partial inpatient care programs.

(2) Closed patient medical case records will include patients in an inactive status and those pending transfer of record. These records will be maintained as inactive records and retained for a period of 5 years. Patients referred to as being in the inactive patient status include former employees or those screened and returned to units with no further action indicated. Former participants of ADAPT or ASAP treatment are filed in the inactive records when not receiving follow-up.

b. Access to individual ASAP patient medical records will be restricted to the following:

(1) Rehabilitation staff members.

(2) AMEDD designated personnel involved in the treatment of individual patients and AMEDD evaluators who will be charged with determining the extent of compliance with this regulation. Only USAMEDCOM personnel participating as members of official inspection teams have access.

9-7. Management information feedback reports

a. Direct communication between Director, ACSAP and installation ADCOs is authorized. The ACSAP will maintain an historical database of ASAP data collected from DA Forms 3711, DA Forms 4465, and DA Forms 4466 that will be used for program management and strategic program planning.

b. The ACSAP will send management reports to each installation, MSC, and MACOM ADCO. This information will be derived from the DA Form 3711, DA Form 4465, and DA Form 4466 submitted to ACSAP. The ADCO will disseminate reports to the CD.

c. The ACSAP will provide ADCOs and CDs information outlining the accuracy and timeliness of DA Form 3711, DA Form 4465, and DA Form 4466 received from their installation.

Chapter 10 Program Evaluation

10-1. Scope

a. Program evaluation is an integral part of ASAP planning which is intended to assist administrators and managers at all levels in decision making and management.

b. Evaluation will be accomplished through regular management reporting, assistance visits, program element evaluations, and external evaluations requested by the DCSPER.

c. ASAP evaluations, in coordination with MACOMs:

(1) Determine if program objectives are being met.

(2) Determine program effectiveness and efficiencies, including commanders' and other customers' perceptions.

(3) Obtain data for development of policies and procedures and determining resources or allocations.

(4) Determine problem areas and requirements for technical assistance at specific installations.

(5) Determine compliance with directives.

(6) Provide feedback as a basis for program improvement and allocation of dollar and staff resources.

10–2. Staff assistance inspection (SAI) and Installation biochemical testing program inspection (IBTPI)

- a.* Army Center Substance Abuse Program will make SAIs to the program sites at least once every 2 years. ACSAP will focus on the non-clinical functions. When possible SAIs will be conducted jointly with USAMEDCOM.
- b.* ACSAP will make IBTPIs to program sites to the extent possible at least every 3 years. IBTPIs will focus on the entire biochemical testing program and may be conducted jointly with the SAI if possible.
- c.* ACSAP and USAMEDCOM will also conduct SAIs and or IBTPIs at the request of the DCSPER; CAR; CNGB; MACOM commanders, or the installation commanders.
- d.* The schedule of ACSAPs SAIs and IBTPIs will be based on results of previous visits; time elapsed since last visit, and statistical data.
- e.* MACOMs will conduct annual SAIs.

Chapter 11 ASAP Non-clinical and Clinical Staff Training

11–1. General

Sustaining and improving the skills and proficiency of the ASAP staff require continuing professional development training programs that meet the complex technical needs of the entire staff. The Director, ACSAP is responsible for the professional development training of the ASAP non-clinical staff and will manage life cycle training through the Army Civilian Training and Education System. The installation commander is responsible for resourcing the professional development training of all ASAP non-clinical positions. USAMEDCOM and the Army Medical Department Center and School (AMEDDC&S) are responsible for the professional development training of all ASAP clinical positions.

11–2. Non-clinical DA sponsored staff training

The Director, ACSAP is the proponent for IPTT, ADCO, PC, EAPC, UPL, and IBTC training, and will develop a budget for all non-clinical training requirements. The Director, ACSAP will publish a training schedule annually which includes complete course descriptions and eligibility criteria. Course nominations will be forwarded and coordinated through MACOMs to ACSAP.

11–3. Leadership training and schools

TRADOC will ensure that current and appropriate training on the ASAP clinical and non-clinical components is integrated at all levels of Army professional development. The ACSAP and AMEDD staffs will be available to provide training at senior leadership training courses. The AMEDDC&S will provide training to all AMEDD Officer Basic Course, Officer Advanced Course, Basic Noncommissioned Officer Course, and Advanced Noncommissioned Officer Course students.

11–4. Training products

The ACSAP will develop and distribute training modules on key ASAP non-clinical program elements. USAMEDCOM, through AMEDDC&S, will develop and offer training modules for ASAP clinical personnel. Training products will be updated periodically, be consistent with Army policy, and be automated and capable of being electronically delivered whenever possible.

11–5. ASAP staff certification

- a.* Installation EAPCs must gain certified EAP professional status within four years of assuming duties. Existing EAPCs have until 4 years from published date of this regulation. Individuals will be responsible to apply for certification, training and for maintaining all professional development requirements once they are certified. ADCOs are encouraged to gain certified EAP professional status.
- b.* Prevention Coordinators will be certified through the ACSAP.
- c.* Installation Biochemical Test Coordinators will be certified through ACSAP's IBTC course.
- d.* Unit Prevention Leaders must complete ACSAP's standardized certification course.

11–6. Clinical USAMEDCOM sponsored training

a. USAMEDCOM is the proponent for all clinical and medically related training. Formal courses will be offered by AMEDDC&S, which will publish a training schedule with complete course descriptions and eligibility criteria. Course nominations will be forwarded annually to AMEDDC&S Alcohol and Drug Training Section. Newly assigned Clinical Consultants and CDs will attend an orientation training session at AMEDDC&S within 120 days of assignment. All other clinical personnel will attend required training within 6 months of assignment. All clinical staff will attend AMEDDC&S sponsored continuing education training in order to maintain clinical skills and remain current with DA

policies. The AMEDDC&S will sponsor Additional Skill Identifier training (M8 and Z qualifier) for eligible active and reserve component soldiers.

b. Clinical Consultants will receive the orientation described in paragraph 11-6a of this regulation and will be offered continuing medical education training at AMEDDC&S every 2 years.

c. CDs will receive orientation described in paragraph 11-6a of this regulation and will participate in continuing education training at AMEDDC&S.

d. Civilian counselors will attend required AMEDDC&S courses within 6 months of assignment and will complete continuing education training at AMEDDC&S.

11-7. Deployment training

AMEDDC&S will design and furnish deployment specific training packages for Mental Health and Combat Stress Control Medical units. The ACSAP and installation ASAP will provide substance abuse prevention and risk reduction training for those elements.

Chapter 12

Army Substance Abuse Program (ASAP) in the Army National Guard of the United States (ARNGUS)

Section I

General

12-1. Scope

This chapter establishes policies, responsibilities, and specific procedures for implementing and managing the ASAP within the Army National Guard (ARNG).

12-2. Applicability

a. This chapter applies to all ARNG soldiers, except for personnel in the following duty categories: (All soldiers in the following 5 categories fall under Active Army Control and other provisions of this regulation.)

(1) Active duty of 30 days or more that is not for training, including AD in an Active Guard Reserve status under title 10 USC.

(2) Special tours of active duty training (ADT) of 30 days or more.

(3) Initial active duty training (IADT).

(4) Involuntary ADT of 45 days.

(5) Soldiers ordered to AD status during periods of partial, full, or total mobilization.

b. State employees and Federal technicians are not serving in a military duty status while employed in those capacities, and this chapter does not apply to them unless otherwise stated.

Section II

Scope of Duties

12-3. The Director, Army National Guard (ARNG)

The Director, ARNG will develop and execute plans, policies, and procedures of the ARNG ASAP.

12-4. The Chief Surgeon, ARNG

The Chief Surgeon will provide technical consultation on all medical aspects of the ARNG ASAP.

12-5. The Director, Counterdrug Directorate, National Guard Bureau (NGB-CD)

The Director, NGB-CD will develop policy and regulatory guidance concerning program funding, internal control, and evaluation.

12-6. The Chief, Substance Abuse Branch

The Chief, Substance Abuse Branch will administer, manage, and provide direction to the ARNG ASAP and will—

a. Establish requirements and prepare budget requests for ARNG funds to support the ASAP.

b. Determine, allocate, and manage urinalysis quotas for the States and Territories.

c. Provide liaison with HQDA and other agencies on ASAP matters.

d. Develop and provide guidance to the State MROs and State ADCOs regarding funding requirements and drug testing quota utilization.

12-7. The State Adjutants General

State Adjutants General will provide program management and operational supervision of the ARNG ASAP within their State or Territory and will—

- a.* Ensure that State policies and standards are clearly understood and adhered to by all ARNG members.
- b.* Designate a State ADCO on orders.
- c.* Designate a State MRO on orders.

12-8. State ADCOs

Each State ADCO will act as the principal staff officer for coordinating and managing the ARNG ASAP for their respective State Adjutant General. State ADCOs will—

- a.* Ensure that the State Counterdrug Coordinator is informed of all ASAP issues.
- b.* Coordinate State ARNG activities in the area of substance abuse, to include internal prevention, education, training, identification, referral, follow-up, and program evaluation.
- c.* Manage and allocate drug-testing quotas within the State in accordance with the policies and priorities established by the NGB and the State Adjutant General.
- d.* Establish and maintain coordination with the State's assigned FDTL.
- e.* Train all ASAP personnel in drug urinalysis collection procedures.
- f.* Provide periodic program evaluation to the State Adjutant General and required reports to the NGB.
- g.* Maintain the State ASAP record and reports.
- h.* Identify State certified, community-based alcohol and other drug referral, counseling, and rehabilitation services and to ensure that this information is made available to unit commanders for use in the referral process.
- i.* Serve as a member of the Alcohol Drug Intervention Council (ADIC).
- j.* Coordinate with the ADCO of the Active Component installation(s) assigned garrison support responsibilities, the respective Clinical Director (CD), and the Regional Medical Command (RMC) regarding available ASAP support.

12-9. Major Army Command Alcohol Drug Control Officers

MACOM ADCOs will act as the principal staff officer for coordinating and managing the MACOM ASAP under the direction of the State ADCO.

12-10. Unit Prevention Leaders (UPLs)

UPLs will—

- a.* Advise and assist the unit commander in carrying out the responsibilities of the ARNG ASAP.
- b.* Administer the unit biochemical-testing program.
- c.* Provide education and prevention training to all soldiers.
- d.* Brief all new unit personnel regarding ASAP policies and requirements.
- e.* Inform the unit commander the status of the ASAP and the trends in alcohol and other drug abuse in the unit.
- f.* Maintain unit ASAP records and reports.

Section III

Policies and Procedures

12-11. Policies

Illegal drug use is misconduct and the abuse of alcohol or the use of illicit drugs by both military and civilian

personnel is inconsistent with the standards of performance, discipline, and readiness necessary to accomplish the Army's mission.

a. ARNG soldiers identified as illegal drug users simultaneously will be:

(1) Counseled by the unit commander for enrollment in the ARNG ASAP within 45 workdays of verified positive drug test.

(2) Processed for administrative separation within 45 days of receipt of the verified positive drug test. Soldiers may be considered for disciplinary action prior to separation.

(3) Evaluated for continued eligibility for access to classified information and reported to the U S Army Central Personnel Security Clearance Facility per AR 380-67.

b. ARNG soldiers involved in alcohol related misconduct such as drinking on duty, drunk on duty, or operating a motor vehicle while intoxicated will be:

(1) Counseled by the unit commander for possible enrollment in the ARNG ASAP within 45 workdays of being identified for possible alcohol abuse.

(2) Considered for administrative separation and/or disciplinary action.

(3) Evaluated for continued eligibility for access to classified information and reported to the U S Army Central Personnel Security Clearance Facility per AR 380-67.

12-12. Funding considerations

a. Counterdrug ARNG Operation and Maintenance funds will be used to pay for:

(1) Supplies and shipping material for the collection and shipment of urine specimens to the toxicology laboratory.

(2) Litigation and/or Commander's Packets (See para 8-5 of this regulation) and related costs. Each State/Territory will submit a request for a Litigation Packet to the toxicology laboratory and provide a copy of the request to the Chief, Substance Abuse Branch. The Litigation Packet will be ordered by the State Judge Advocate General or State ADCO. Counterdrug Operation and Maintenance funds may be used for payment of expert witness and telephone consultants' fees when approved by the Chief, Substance Abuse Branch.

(3) Prevention, education, and training materials, and services for soldiers and their families.

b. Counterdrug ARNG Pay and Allowance funds may be used to pay for:

(1) ASAP training, including travel costs to conferences and seminars.

(2) Urine collections.

(3) Administrative separation boards.

(4) ASAP administrative support.

c. Counterdrug funds will not be used to pay for alcohol and/or other drug treatment or rehabilitation for ARNG soldiers.

12-13. Alcohol Drug Intervention Council (ADIC)

Chapter 2 of this regulation applies to the ARNG, except that:

a. An ADIC will be established at the State level to function in an advisory capacity to the State Adjutant General.

b. The ADCO will provide continuous assessment of the alcohol and other drug environment within the ARNG of that State.

12-14. Referral of alcohol and illegal drug abusers to the ARNG ASAP

Chapter 3 of this regulation applies to the ARNG, except that:

a. When ARNG soldiers are identified voluntarily or involuntarily as a possible alcohol or other drug abuser, the unit commander or designated representative will promptly:

(1) Counsel and advise the soldiers of their rights under the appropriate provisions of the State law pertaining to self-incrimination using the appropriate State Rights Warning Procedure/Waiver Certificate, and explain the "Limited Use Policy" addressed in section III, chapter 6 of this regulation.

(2) Refer soldiers to community-based counseling and rehabilitation programs using a DA Form 4856 (General Counseling Form) or another State-approved counseling form. The unit commander must provide soldiers with a list of State certified and/or approved counseling/treatment agencies that are within a reasonable commuting distance of the soldiers' residences. Soldiers must be advised that:

(a) They must be screened/evaluated within 30 days of the command counseling session.

(b) They are responsible for all costs incurred in any referral/rehabilitation programs. Soldiers should be encouraged to explore available treatment options (for example, a sliding fee based on income, use of health insurance, Medicaid, and so forth.) with treatment program personnel.

(c) They must sign a consent statement that allows the treatment personnel to share necessary treatment information with the unit commander or designee. Soldiers must request that treatment personnel provide monthly updates in writing to unit commanders, who must be kept informed regarding the progress of treatment. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment will not satisfy the rehabilitation requirements of this chapter. Soldiers

may refuse to sign the consent statement. However, these soldiers may be deemed not to be participating sufficiently in rehabilitation. Refusal to sign may result in their being processed for administrative separation for rehabilitation failure.

(d) Failure to participate in and successfully complete approved State or ASAP counseling and treatment program, or the refusal to sign a consent to release information to the unit commander, will result in consideration for separation under AR 135-175 or AR 135-178.

b. ARNG soldiers on IADT or other AD of 30 days or more will use Active Component ASAP services while in an AD status or until treatment is complete.

12-15. Rehabilitation

Chapter 4 of this regulation applies to all active duty ARNG soldiers.

a. The goal of the ARNG ASAP rehabilitation program is to return rehabilitated soldiers to full effective duty as early as possible.

b. The ARNG unit commander must be innovative and empathetic when working with those soldiers enrolled in rehabilitation. The unit commander must be kept informed regarding the soldier's progress.

c. When an ARNG soldier is detoxified at Army expense, an appropriate line of duty determination will be made in accordance with chapter 4 of this regulation.

12-16. State MROs

A State MRO determines if positive drug results reported by the toxicology laboratory could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures.

a. The MRO may be the State Surgeon or other medical doctor within the State ARNG provided those appointed have been trained and certified to perform MRO duties. Physician's assistants, pharmacists, and nurses will not be appointed as the MRO.

b. When a drug test has been reported positive by the toxicology laboratory for a drug with a possible legitimate medical use as determined by USAMEDCOM, the unit commander will offer the soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the soldier's physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and the medical reason for its use. The documentation will be marked "Confidential" and will be forwarded through the ADCO to the MRO for evaluation. Unit commanders will not initiate any unfavorable action against the soldier identified until the MRO had rendered an evaluation

(1) If the MRO verifies medically justified use, the unit commander and the State military personnel officer will be notified promptly and no further action is required.

(2) If the MRO confirms illegal drug use, the unit commander and the State military personnel officer will be notified promptly and the unit commander will counsel the soldier in accordance with paragraph 12-11 of this regulation. The unit commander will process the soldier for separation through the military personnel office to the discharge authority.

(3) If the MRO is unable to make a determination without talking directly with the soldier, the ADCO will schedule an appointment to allow the soldier to meet directly with the MRO.

12-17. Administratively separating drug abusers

Chapter 5 of this regulation applies to the ARNG, except that:

a. Unit commanders will process all ARNG soldiers identified as illegal drug users for administrative separation.

(1) Officers and Warrant Officers will be processed under the provisions AR 135-175 and applicable NGB regulations.

(2) Enlisted personnel will be processed under the provisions of AR 135-178 and applicable NGB regulations.

b. If an ARNG soldier refuses to consent to drug testing, the unit commander or a designated representative within the soldier's chain of command will order the soldier to provide a specimen. Soldiers who refuse to participate, violate a direct order and may be processed under applicable State code for disciplinary action and/or judicial or nonjudicial punishment; in addition to processing for separation and other administrative actions outlined under this regulation.

12-18. Biochemical testing guidance

Chapter 8 of this regulation applies to the ARNG, except that:

a. Mandatory testing requirements include the addition of all AGR and AD for Special Work counterdrug personnel according to NGR 500-2.

b. The ARNG is prohibited from urine drug prescreening (field-testing).

c. Due to the geographical separation of ARNG units and ASAP staff, all urine specimens will be shipped directly from the unit to the FTDTL using the proper chain of custody and procedures.

12-19. Management information system

Chapter 9 of this regulation does not apply to the ARNG. Management information will be reported in accordance with NGR 600-85.

12-20. Evaluation

Chapter 10 of this regulation does not apply to the ARNG. Program evaluation will comply with guidance provided by the Director, NGB-CD.

12-21. Quota allocation process

- a.* The Director, ARNG will establish annual drug testing goals and requirements.
- b.* Prior to 1 June, each State/Territory will request quotas from the Director, NGB-CD for the coming fiscal year. State quota requests will reflect the goals of the Director, ARNG.
- c.* States may request an adjustment of quotas from the Director, NGB-CD for any given month. Requests must be made in writing no later than 2 months before the testing date.

12-22. Military justice

Incidents involving alcohol or other drug abuse may also constitute a basis for violation of State law and/or a State military justice code. Soldiers may be processed under applicable State code for disciplinary action and/or judicial or nonjudicial punishment in addition to separation and other administrative actions outlined under this regulation.

Chapter 13

Army Substance Abuse Program (ASAP) in the U.S. Army Reserve (USAR)

Section I

General

13-1. Scope

This chapter establishes policies, responsibilities, and specific procedures for implementing and managing the ASAP within the USAR.

13-2. Applicability

- a.* This chapter applies to USAR soldiers while not on AD for 31 days or more in the following categories:
 - (1) Troop program units.
 - (2) Individual Mobilization Augmentee Program.
 - (3) Individual Ready Reserve.
 - (4) Soldiers serving on various tours of ADT, Temporary Tours of AD, and AD for Special Work for less than 31 days. Soldiers performing tours of 31 days or more will comply with provisions listed for Active Component personnel.
- b.* This chapter does not apply to USAR soldiers activated under a Presidential Selected Reserve Call-up, partial, full, or total mobilization. ASAP policies for Active Component soldiers apply to these personnel.

Section II

Duties

13-3. The Chief, Army Reserve (CAR)

The CAR will—

- a.* Recommend policies and operational tasks to the DCSPER regarding the participation of USAR component soldiers and their families in the ASAP.
- b.* Ensure that USAR units comply with ASAP policy.
- c.* Advise the DCSPER regarding alcohol and other drug abuse and the impact of the ASAP on the USAR.

13-4. Commander, USAR Personnel Command (AR-PERSCOM)

At the direction of HQDA (DAAR-PE), the Commander, AR-PERSCOM will—

- a.* Collect and disseminate ASAP information.
- b.* Provide reports concerning performance analysis to HQDA (ATTN: DAAR-PE), 2400 Army Pentagon, Washington, DC 20310-2400.

13-5. Commanders of area commands

Commanders of area commands will (USARC, USACAPOC, 7th ARCOM, 9th ARCOM, AR PERSCOM)—

- a.* Establish an alcohol and other drug control office within their headquarters.
- b.* Designate an ADCO on orders that can be filled by an AGR soldier, Active Component member, or a DA civilian.
- c.* Designate an MRO on orders.
- d.* Ensure continued support to tenant USAR units in the execution of this regulation's requirements.

13-6. Area command ADCOs

Area command ADCOs will—

- a.* Provide annual Program Budget Guidance in support of the ASAP.
- b.* Publish annual guidance for audit procedures of ASAP funds.
- c.* Develop an internal management control program checklist for ASAP funding execution.
- d.* Manage and allocate urinalysis quotas based upon regulatory guidance to include priority Military Occupational Specialties for mandatory annual testing, and publish a monthly urinalysis statistical evaluation report.
- e.* Evaluate the command's ASAP for effectiveness.
- f.* Provide guidance for the effective operations of the subordinate commands' ASAP.
- g.* Conduct SAVs to subordinate commands.
- h.* Coordinate ADCO training requirements and ensure regular training programs are available to the commands.
- i.* Assemble and disseminate information concerning Active Component ASAP and State certified community-based alcohol and other drug referral, counseling, and rehabilitation services to subordinate commands.

13-7. Commanders of major U.S. Army Reserve commands (MUSARCs)

Commanders of MUSARCs will—

- a.* Establish an alcohol and other drug control office within their headquarters.
- b.* Designate the following on orders:
 - (1) An ADCO to serve as the principal staff officer for coordinating and managing the command's ASAP.
 - (2) An MRO, when it is not possible to appoint an MRO from within available personnel resources, support will be provided by the chain of command. If the MRO support crosses MUSARCs, a Memorandum of Understanding will be prepared and a copy provided to the next higher headquarters.
 - (3) A UPL to assist the commander in managing and conducting the unit's ASAP.

13-8. MUSARC ADCOs

MUSARC ADCOs will—

- a.* Advise the commander on all ASAP issues.
- b.* Develop and coordinate local ASAP policies and procedures.
- c.* Provide data for budget and manpower planning, develop funding controls, and maintain appropriate records of all ASAP resource transactions and testing within their subordinate commands.
- d.* Manage and conduct the command's biochemical testing program.
- e.* Ensure MROs receive test results requiring review in a timely manner.
- f.* Ensure that the MRO and the UPLs are trained and certified as required for their duties.
- g.* Program Operation and Maintenance, Army Reserve and Reserve Personnel, Army funding for the command's ASAP.
- h.* Assemble and disseminate information concerning Active Component ASAP and State certified community-based alcohol and other drug referral, counseling, and rehabilitation services to subordinate commands.
- i.* Report positive tests, which do not require medical review (that is, THC, Cocaine, LSD, and PCP), to an appropriate USACIDC field element or PM.

Section III

Policies and Procedures

13-9. Policies

The objective of the USAR program is to sustain a well disciplined, mission capable force ready for mobilization. As deployability is dependent upon a drug free membership, abuse of alcohol or other drugs is incompatible with service in the USAR. Well organized and effective programs in urinalysis testing and alcohol and other drug prevention and education are critical to achieving this objective.

- a.* USAR soldiers identified as illegal drug abusers will be:
 - (1) Counseled by the unit commander, in person or by certified mail, (See referral processing guidance in para 13-13 of this regulation) for possible enrollment in the USAR ASAP. Command counseling sessions will be conducted

within 30 calendar days, or by the close of the next drill session, after the receipt of MUSARC MRO-verified positive drug test report.

(2) Flagged immediately in accordance with AR 600-8-2 using DA Form 268 (Report to Suspend Favorable Personnel Actions) to suspend favorable personnel actions until separation procedures for misconduct are adjudicated.

(3) Processed for administrative separation. Processing will be initiated within 30 calendar days of receipt of the MUSARC MRO-verified positive drug test report. In addition, soldiers may be considered for disciplinary action under the UCMJ if use on AD can be validated.

(a) Officers and Warrant Officers will be processed under the provisions of AR 135-175.

(b) Enlisted personnel will be processed under the provisions of AR 135-178.

(4) Evaluated for continued eligibility for access to classified information and reported to the U S Army Central Personnel Security Facility per AR 380-67.

b. Commanders will not release information on positive drug results or initiate administrative actions until an MRO review and evaluation is completed.

c. The USAR urinalysis testing rate of one random sample per Selected Reserve member annually will mirror that of the Active Component testing rate as closely as operationally possible. Special attention is directed to compliance with specific annual testing requirements for members of, or in duty positions of, aviation and military police branches, and soldiers participating in counterdrug operations.

d. USAR soldiers involved in alcohol related misconduct such as drinking/drunken on duty or operating a motor vehicle while intoxicated will be:

(1) Counseled by the unit commander (See referral process in para 13-12 and 13-13 of this regulation) for possible enrollment in the USAR ASAP. Command counseling will occur within 30 calendar days of the soldier's identification for possible alcohol related abuse, if operationally possible.

(2) Flagged (using DA Form 268) immediately in accordance with AR 600-8-2 until separation procedures under appropriate regulations for misconduct are adjudicated if a soldier has one or more instance of alcohol related misconduct.

(3) Have their current duty assignment reviewed, and be relieved from duty if warranted. Ensure relief for cause is recorded.

(4) Have their service record reviewed by the MUSARC commander to determine if one or more of the following actions are warranted:

(a) Administrative reduction in rank for inefficiency under the provisions of AR 140-158.

(b) Bar to reenlistment.

(c) Relief for Cause evaluation report.

(d) Administrative discharge/or disciplinary action under UCMJ, if applicable.

(e) General Officer Letter of Reprimand.

(5) Evaluated for continued eligibility for access to classified information and reported to the U S Army Central Personnel Security Facility per AR 380-67.

e. USAR soldiers who are mobilized or are on AD for more than 30 days will be promptly tested for illegal drug use.

13-10. Prevention and control

Chapter 2 of this regulation applies to the USAR, except that:

a. The USAR will establish ASAP prevention and education programs at the lowest command level which emphasize the incompatibility of substance abuse and continued service in the USAR. The USAR ASAP is a commander's program, and MUSARC commanders are encouraged to establish ADICs at the lowest possible command level. The mission of the ADIC will be to outline the command's substance abuse prevention strategies and evaluate the program's effectiveness within the command.

b. The MUSARC will include USAR soldiers' family members. The MUSARC's Family Readiness Program Manager will coordinate family member involvement in their ADIC counterpart as well as Drug Demand Reduction Programs.

13-11. Referral of alcohol and illegal drug users in the USAR ASAP

Chapter 3 of this regulation applies to the USAR, except that:

a. When the unit commander believes the limited Use Policy applies, the unit commander should consult with the ADCO and the supporting legal advisor. The unit commander may then explain Limited use Policy if applicable to the particular circumstances. If the unit commander determines the Limited Use Policy does not apply, the commander should then advise the soldier of suspected drug or alcohol abuse of the rights under UCMJ Article 31 (b) and MRE 305, and if available ask the soldier to sign the DA Form 3881, Right Warning Procedure/Waiver Certificate.

b. Refer the soldier to a community-based, State-certified counseling and rehabilitation program using DA Form 4856. The commander must provide the soldier with a list of State-certified and/or approved counseling/treatment

agencies that are within a reasonable commuting distance of the soldier's residence. (USAR will not provide transportation or any clinical services to include screening/assessment, rehabilitation/treatment and follow-up services.) Additionally, soldiers will be advised that they:

(1) Must promptly arrange for a screening/intake session, which should take place not later than 30 days from date of the command counseling session.

(2) Sign a consent statement for release of treatment information, which allows the treatment personnel to share necessary information with the commander or designee. The commander must be kept informed regarding the progress of treatment. Soldiers must request that treatment personnel provide written monthly updates to the commander. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment will not satisfy the rehabilitation requirements of this chapter. Soldiers may refuse to sign the consent statement. However, these soldiers may be deemed not to be participating sufficiently in rehabilitation. Refusal to sign may result in their being processed for separation for rehabilitation failure.

(3) Must understand that failure to seek counseling and treatment, refusal to sign a consent to release information to the commander, or to participate and complete rehabilitation successfully, may result in consideration for administrative separation under AR 135-175 or AR 135-178, as appropriate.

13-12. Rehabilitation

Chapter 4 of this regulation applies to USAR members when on extended AD for more than 30 days. When a USAR soldier is detoxified at Army expense, an appropriate line of duty determination will be made to ascertain the soldier's fitness for subsequent return to duty if warranted.

13-13. Medical Review Officers

The MRO determines if positive drug test results reported by the toxicology laboratory could have resulted from the legal use of a prescription drug for medical reasons and/or for drugs administered during surgical or dental procedures.

a. The MRO must be a physician, trained and certified to perform MRO functions, and appointed in writing. Physician assistants and pharmacists will not be appointed as MROs.

b. When a drug test has been reported positive by the toxicology laboratory for a drug with a possible legitimate medical use as determined by USAMEDCOM, the unit commander will offer the soldier the opportunity to furnish medical evidence in the form of a medical prescription and/or statement from the soldier's physician or dentist documenting the drug prescribed or given, date of medical or dental procedure which required prescribed drugs, and the medical reason for its use. The documentation will be marked "Confidential" and will be forwarded through the ADCO to the MRO for evaluation. Unit commanders will not initiate any unfavorable action against the soldier identified until the MRO had rendered an evaluation.

c. If the MRO is unable to make a determination without talking directly with the soldier, the unit commander will schedule an appointment to allow the soldier to meet with the MRO if practical. If not practical, the MRO will conduct the interview by telephone.

d. When the MRO has made a determination regarding the cause of the positive drug test results the unit commander will be notified promptly.

(1) If the MRO determines medically justified use, then no further action is required.

(2) If the MRO determines illegal drug use, then actions will be taken in accordance with paragraph 13-9a of this regulation.

13-14. Biochemical testing guidance

Chapter 8 of this regulation applies to the USAR, except that:

a. The USAR is prohibited from urine drug prescreening (field-testing).

b. The area commander, MUSARC commander, unit commander, or their designated representatives will randomly identify individual soldiers, parts of units, or entire units for random drug testing. Random drug testing quota requests will be in writing and approved by the MUSARC commander. All random drug tests will be unannounced.

c. If a soldier refuses to consent to drug testing, the soldier will be given a direct order by the unit commander to provide a specimen. Refusal to participate constitutes a violation of a direct order and may result in UCMJ action.

d. Due to the geographical separation of USAR units and MUSARC ASAP ADCO staff, all urine specimens will be shipped directly from the unit that is administering drug testing to the appropriate supporting toxicology laboratory. Proper chain of custody procedures are required.

13-15. Management information system

Chapter 9 of this regulation and the following additional requirements apply to the USAR.

a. Each MUSARC will submit monthly, a DA Form 3711 through command channels to their area command. The

area command ADCO will consolidate and maintain a statistical summary of these reports and provide it monthly to the program manager at AR-PERSCOM. (See para 13-4 of this regulation for AR-PERSCOM reporting requirements.)

b. MUSARC ADCOs will maintain individual files on soldiers referred to community-based counseling and rehabilitation centers which track the beginning dates, completion dates, and reasons for disenrollment from rehabilitation, to include reasons for failure to meet the rehabilitation/treatment standards.

13–16. Evaluation

Chapter 10 of this regulation does not apply to the USAR. The operation of the USAR ASAP must include a comprehensive program of evaluation to determine program effectiveness, progress and attainment of specific goals and objectives established by the CAR. Technical support and program evaluation of the USAR ASAP will be conducted through the MUSARC ADCOs and area command ADCOs. The MUSARC ADCO will forward a summary report of their ASAP program effectiveness to their area command. The area command ADCO will provide a summary of the overall effectiveness of the ASAP to the program manager at AR-PERSCOM, which will analyze for overall program effectiveness in the USAR. The area command ADCOs will make periodic visits to the MUSARCs to evaluate their overall ASAP effectiveness and progress, and will further provide training assistance support to enhance the ASAP as necessary. Minimum evaluation standards should:

a. Stress the impact of the USAR's ASAP policies, goals and objectives on all USAR soldiers and civilians employed by the USAR.

b. Seek comparisons of the relative effectiveness concerning the various approaches on ASAP prevention and education techniques in the MUSARCs and the overall effectiveness, productivity, and efficiency of Army approved community-based treatment and rehabilitation programs used by USAR soldiers who have returned to full productive duty.

c. Obtain after action reports on the effectiveness, usefulness, and efficiency of different supporting agencies.

d. Determine the overall effectiveness of various ASAP approaches to various target groups within the MUSARC.

e. Ensure full integration on all facets of the USAR ASAP at each area command. This will be for the purposes of consistency of prevention, education, and training, and substance abuse testing controls and measures for urinalysis chain of custody procedures and reporting. The intent is to alleviate high urinalysis dump rates at the supporting toxicology laboratory due to inaccurate data on the chain of custody report by the MUSARCs.

f. Provide feedback and recommended improvements and/or changes to the MUSARC ASAP or the area commanders, to include economy of funding and staffing resources, program effectiveness, program trends, and recommended changes to goals and objectives as they are met.

g. Identify possible areas for research by the CAR.

13–17. Military justice

Incidents involving alcohol or other drug abuse may also constitute a basis for violation of local, State, and Federal laws. The processing of recommendations for disciplinary/or nonjudicial punishment for actions regarding alcohol abuse, alcohol related incidents of misconduct, or drug abuse will be according to local, State, or Federal codes, and the provisions of the UCMJ and applicable Army regulations.

Chapter 14

Army Substance Abuse Program (ASAP) Civilian Services

Section I

Introduction

14–1. Policies

This chapter specifies policies of the ASAP pertaining to DA civilian employees, military and civilian employee family members, and military retirees and their family members. Additional instructions and procedural guidance are provided in chapter 1, DA Pam 600-85. It is Army policy that:

a. DA civilian employees must refrain from alcohol abuse or using drugs illegally, whether on or off duty. Substance abuse is inconsistent with the high standards of performance, discipline, and readiness necessary to accomplish the Army's mission.

b. Reducing or eliminating alcohol and/or other drug misuse or abuse creates safe, healthful, productive, and secure workplaces.

c. Supervisors will be encouraged to use the EAP, which helps employees with problems that may affect their well-being and ability to perform their duties. EAP procedures and instructions are provided in chapter 2, DA Pam 600-85.

d. DA civilian employees, military and civilian employee family members, and military retirees will be offered

screening, short-term counseling and referral services for treatment or rehabilitation for alcohol misuse or other drug abuse, use of illegal drugs, and/or related problems.

- e.* ASAP treatment services will be offered when clinical resources are available.
- f.* Civilian employees and family members' enrollment in ASAP treatment is voluntary.
- g.* Civilian employees have the option of participating in either the installation ASAP clinical program, when available, or being referred to an approved program in the civilian community.
- h.* Whenever possible, an employee's family will be involved in treatment.
- i.* DA civilian employees will be granted an approved absence to obtain treatment according to existing civilian personnel regulations.
- j.* DA civilian employee performance appraisals will not mention current or past enrollment in the ASAP.
- k.* Support of recognized labor organizations for those portions of the ASAP applicable to DA civilian employees is encouraged.
- l.* Drug testing of DA civilians will not be conducted under this regulation for the purpose of gathering evidence for use in criminal proceedings.

14-2. Eligibility

ASAP civilian services are authorized within resource constraints for all DA civilian employees in appropriated and nonappropriated fund positions, military and civilian employee family members, and military retirees and their family members. Also eligible are nonuniformed OCONUS personnel who are eligible to receive military medical services, as well as some foreign nationals where Status of Forces Agreements or other treaty arrangements provide for medical services.

14-3. Labor relations

Questions regarding labor relations implications and responsibilities concerning the civilian drug abuse testing program will be addressed through command channels to HQDA (ATTN: SAMR-CPP-LR), 111 Army Pentagon, Washington, DC 20310-0111. Activities must complete their statutory and applicable contractual labor relations obligations prior to implementing the terms of this regulation as they relate to the conditions of employment of bargaining unit members. (Refer to para 1-3, DA PAM 600-85 for additional instructions on processing labor relations issues regarding ASAP.)

Section II

Areas of Responsibility

14-4. MACOM employee assistance program administrator (EAPA)/prevention program administrator (PPA)

The EAPA will—

- a.* Advise and inform the MACOM ADCO on all matters pertaining to ASAP civilian services.
- b.* Provide staff and technical guidance to installation EAPCs.
- c.* Ensure quality control of non-clinical civilian services.
- d.* Serve as liaison between EAPCs and the Director, ASAP on matters pertaining to manpower, budget, and administration of civilian services.
- e.* Monitor the Army's Drug-free Federal Workplace (DFW) and DOT alcohol and other drug testing programs.
- f.* Collect and maintain data on the status of civilian employees and family member participation in the ASAP and provide reports as required.

14-5. Installation ADCOs

ADCOs will—

- a.* In consultation with the servicing CPAC and management, the ADCO will identify all DFW testing designated positions (TDPs) and those positions subject to the DOT rules.
- b.* Guidance for the selection of TDPs provided in paragraph 14-20 of this regulation. Refer to paragraphs 3-2f (2) and 4-4c(6)(b) DA PAM 600-85 for additional instructions.

14-6. Civilian Personnel Advisory Center (CPAC)

The CPAC will—

- a.* Provide advice and assistance to management when an employee has a confirmed positive drug test under the DFW testing program and or has engaged in DOT prohibited conduct described in 49 CFR Part 382.
- b.* Ensure that local forms deemed appropriate are completed during in-processing.
- c.* Refer to Chapters 3 and 4, DA Pam 600-85 for additional instructions for the CPAC.

14-7. Civilian personnel operations center (CPOC)

The CPOC will—

- a.* Code management-identified TDP employees in the Defense Civilian Personnel Data System (DCPDS) or the successor data system.
- b.* Ensure positions descriptions and vacancy announcements contain appropriate language on random drug testing conditions of employment for all positions identified by supervisors and management officials.
- c.* Ensure that the completed alcohol and drug testing DA Forms 5019 (Condition(s) of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program) and the 7412 are filed in the Official Personnel Folder (OPF).

14-8. Installation EAPCs

EAPCs will—

- a.* Assess, plan, and establish local procedures for providing comprehensive EAP services for eligible DA civilian employees and military and civilian family members within the military community. (Refer to para 2-1, DA Pam 600-85 for a discussion of comprehensive EAP services.)
- b.* Provide screening, short-term counseling and referral services for treatment or rehabilitation to employees who self-refer or whom management refers.
- c.* Provide follow-up services to assist employees in achieving effective readjustment to the job.
- d.* Advise and update supervisors concerning their employees' progress to the extent permitted by applicable law and this regulation.
- e.* Consult with the installation CPAC, MRO, SAP, and supervisors of DA civilians throughout the installation.
- f.* Maintain an updated list of available community counseling and treatment resources.
- g.* Present prevention education and training to supervisors and DA civilians at all levels on alcohol and other drugs and on how to use EAP services properly. (Refer to para 2-4, DA Pam 600-85 for employee education and supervisory training prerequisites.)
- h.* Publicize ASAP services available for civilian employees.
- i.* Develop prevention campaigns and assist the PC in providing education and prevention programs.
- j.* Collect information required for reports.

14-9. Supervisors of DA civilians

Supervisors will—

- a.* Consult with the CPAC specialist:
 - (1) Before initiating any formal disciplinary or adverse action.
 - (2) Before referring an employee to the ASAP for information, screening, short-term counseling, and referral leading to enrollment for treatment in the ASAP clinic or in a community resource.
 - (3) When an employee appears to be under the influence of alcohol or other drugs while on duty.
- b.* Notify appropriate law enforcement authorities when there is reasonable suspicion that an employee is engaged in criminal conduct involving alcohol or other drugs (e.g., trafficking, theft, or illegal possession).
- c.* Refer to paragraph 2-3, DA Pam 600-85 for additional instructions and procedures for supervisors of civilian employees.

Section III

Employee Assistance Program (EAP)

14-10. Screening and referral

Civilian employees whose job performance, conduct, or attendance record indicates a substance abuse problem requiring professional assistance will be referred to the installation EAPC. Supervisors will refer to the installation EAPC any civilian employee who is found to abuse alcohol or drugs or use illegal drugs. (See DA Pam 600-85, para 2-1a for screening and referral procedures by the EAPC.)

14-11. Medical evaluations

When required, a military or civilian medical officer will conduct the medical evaluation.

14-12. Patient costs

- a.* There will be no direct charge for the following services:
 - (1) Medical evaluations conducted by the Army Federal Civilian Employee Health Services Program, the MTF physician, or the medical consultant.
 - (2) Outpatient civilian services provided by the ASAP counseling center.
- b.* In overseas areas, DA civilians will be provided partial inpatient care when eligible for Army medical services in a foreign country.
- c.* All civilian patients, regardless of location, will be required to provide information on their medical insurance as a part of the enrollment process in the ASAP counseling center. This includes those eligible for CHAMPUS or Third Party Coverage. Their insurance carriers may be billed for services rendered. Patients will not be denied medical services solely because they do not have medical insurance coverage.
- d.* Civilian employees are responsible for all other costs.

14-13. Participation of family members (military or civilian)

Family members, including minor children, may participate in all aspects of the ASAP within the capabilities of existing resources. (Refer to para 2-5, DA Pam 600-85 concerning family members' participation in ASAP civilian services.)

14-14. Confidentiality of patient records

- a.* The confidentiality and disclosure of records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with a Federal substance abuse program is controlled by 42 USC 290dd-2 and 42 CFR Part 2. Generally, disclosure of such records is prohibited except under the following circumstances:
 - (1) The patient has consented in writing in accordance with 42 CFR Part 2, Subpart C.
 - (2) The disclosure is allowed by a court order.
 - (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for scientific research, management or financial audits, or program evaluation.
- b.* An employee does not have to be enrolled in the program in order to be protected by the provisions of 42 USC 290dd-2, so long as the employee is considered a "patient." A "patient" is defined in 42 CFR 2.11 as "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program."
- c.* During the initial screening, the patient will be notified of the Federal confidentiality requirements and will be given a written summary of the Federal laws and regulations. A sample notice can be found in 42 CFR 2.22.
- d.* Patients may have access to their own records, including the opportunity to inspect and copy any records that the program maintains about the patient. A patient's written request for such access, although not required, is encouraged.
- e.* Civilian ASAP records will be maintained in accordance with 42 CFR 2.16; 49 CFR, Part 382; and AR 40-66.
- f.* The Privacy Act of 1974 (As Amended) (5 USC 552a) also applies to all information maintained in a system of records retrievable by reference to an employee's name or other personal identifier.

14-15. Confidentiality of alcohol and other drug tests results

- a.* Release of alcohol and/or other drug test results is governed by provisions of The Privacy Act OF 1974 (As Amended) (5 USC 552a), DOT regulations. PL 100-71, Section 503(e) (5 USC 7301 note) further restricts the release of drug test results.
- b.* The results of a drug test of a civilian employee may not be disclosed without prior written consent of that employee, unless the disclosure would be:
 - (1) To the employee's MRO.
 - (2) To the administrator of any employee assistance program in which the employee is receiving counseling or treatment or is otherwise participating.
 - (3) To any supervisory or management official in the employee's agency having authority to take adverse personnel action against the employee.
 - (4) Pursuant to the order of a court of competent jurisdiction where required by the Government to defend against any challenge against any adverse personnel action.
- c.* The drug-testing laboratory will release drug test results only to the MRO.
- d.* Alcohol and other drug test results may be released to appropriate Army personnel for data collection and other purposes consistent with PL 100-71, Section 503(f); DOT regulations on controlled substances and alcohol use and testing; the DHHS's Mandatory Guidelines for Federal Workplace Drug Testing Programs; and other DA requirements. The disclosure may not include personal identifying information on any employee.
- e.* In accordance with DOT regulations, employees subject to DOT regulations are entitled, upon written request, to copies of and access to records relating to the employee's use of alcohol or controlled substances, including records pertaining to their alcohol or controlled substance abuse test.
- f.* In accordance with PL 100-71, Section 503, Federal employees are entitled, upon written request to have access to

any records pertaining to their test and any records relating to the results of any relevant laboratory certification, review, or revocation of certification proceeding.

Section IV

Drug-free Federal Workplace (DFW) Program

14-16. Objectives

The goal of the Army's DFW drug testing programs for civilian employees is to ensure that workplaces are safe, healthful, productive, and drug-free. To achieve this goal, the Army has implemented drug abuse testing programs for DA civilian employees. The objectives are to:

- a.* Assist in maintaining public health and safety, the protection of life and property, national security, and the internal security of the Army
- b.* Deter substance abuse.
- c.* Identify illegal drug abusers.
- d.* Assist employees who are seeking treatment for illegal drug abuse.
- e.* Assist in determining fitness for appointment or retention in TDPs.

14-17. Applicability

Executive Order 12564, The Drug-free Federal Workplace, which established the goal of a DFW, applies to all DA civilian employees and applicants tentatively selected for TDPs. (See para 14-20 of this regulation defining TDPs.)

14-18. DFW program drug testing categories

To achieve the objectives in paragraph 14-16 of this regulation, six categories of drug testing have been established which fully conform to Executive Order 12564. These categories are: (Refer to para 3-2, DA Pam 600-85 for detailed definitions of DFW drug testing categories)

- a.* Reasonable suspicion testing; When there is reasonable suspicion that any employee uses illegal drugs. Reasonable suspicion testing may be required of any employee in a position which is designated for random testing when there is a reasonable suspicion that the employee uses illegal drugs whether on or off duty. Reasonable suspicion testing may also be required of any employee in any position when there is a reasonable suspicion of on-duty use or on-duty impairment.
- b.* Injury, accident, or unsafe testing; When there is an examination authorized by DOD or DA regarding an accident or unsafe practice. When there is an examination authorized by an appropriate installation or activity commander regarding an accident or unsafe practice. Accordingly employees may be subject to testing when, based on the circumstances of the accident, their actions are reasonably suspected of having caused or contributed to an accident that results in death or personal injury requiring immediate hospitalization or in damage to Government or private property estimated to be in excess of \$10,000.
- c.* Voluntary testing; When an employee volunteers for drug testing.
- d.* Follow-up testing; As a follow-up to counseling or rehabilitation.
- e.* Applicant testing; Before appointment or selection to a TDP.
- f.* Random testing. Periodically after appointment or selection, on a random basis..

14-19. Drug testing procedures

Drug testing procedures for the six DFW drug testing categories listed in paragraph 14-18 of this regulation are provided in paragraph 3-2, DA Pam 600-85.

14-20. Drug-free Federal Workplace Testing Designated Positions

a. Positions defined by Executive Order 12564 as sensitive positions are called TDPs (See Executive Order 12564, Section 7, para (d)). Provided below are the sensitive positions or categories of positions that involve law enforcement, national security, the protection of life and property, or public health or safety which have been identified as TDPs. These positions have duties and responsibilities, which are consistent with the parameters established by the DHHS and the ONDCP.

- b.* Employees in these TDPs are subject to random testing which occurs without suspicion that a particular

individual is using illegal drugs. Frequency of random testing will conform to DOD guidance. (Refer to para 3-2f(6) in DA Pam 600-85 for additional instructions regarding the frequency of random drug testing.)

- (1) Positions which authorize the incumbent to carry firearms.
- (2) Positions which require the incumbent to operate a motor vehicle transporting one or more passengers on at least a weekly basis.
- (3) Operators of motor vehicles who are required to have a commercial driver's license and who drive motor vehicles weighing more than 26,001 pounds, or drive motor vehicles transporting hazardous materials.
- (4) Positions which require the incumbent to maintain a Top Secret clearance or have access to Sensitive Compartmented Information.
- (5) Railroad operating crews and railroad personnel in positions in which the duties include handling train movement orders, conducting safety inspections, or the maintenance and repair of signal systems.
- (6) Aviation flight crewmembers, air traffic controllers, and aviation personnel in positions in which the duties include dispatching, safety inspections, or the repair and maintenance of aircraft.
- (7) ASAP positions in which the incumbent provides direct rehabilitation and treatment services to identified illegal drug users.
- (8) Personnel Reliability Program (PRP) positions, (nuclear duty positions or chemical duty positions) under the provisions of AR 50-5 or AR 50-6.
- (9) Positions, which require duties involving the supervision or performance of controlling and extinguishing fires, and/or the rescuing of people, endangered by fire.
- (10) Positions which require the handling of munitions or explosives in connection with the manufacturing, maintenance, storage, inspection, transportation, or demilitarization of these items.
- (11) Positions which require the incumbents to electroplate critical aircraft parts.
- (12) Front line law enforcement personnel with drug interdiction duties who have access to firearms.

14-21. Identification of additional TDPs

Procedures for requesting additional positions which a MACOM or installation commander wants to designate as a TDP for drug abuse testing are provided in paragraph 3-5, DA Pam 600-85.

14-22. Relationship with disciplinary and adverse actions

In accordance with DODD 1010.9, a DA civilian employee found using illegal drugs may be subject to disciplinary action.

- a. Supervisors must consult with their servicing CPAC before initiating any formal disciplinary or adverse action and before offering referral to an employee to the ASAP. The servicing CPAC will advise the supervisor about options and responsibilities. A range of disciplinary actions is available.
- b. The servicing CPAC will assure appropriate coordination with the labor counselor is accomplished.
- c. DA employees in TDPs who are found to use illegal drugs shall not remain in the TDP.
- d. Upon successful completion of rehabilitation, or as part of a rehabilitation program if progress is evident and the employee poses no danger to health, safety or security, the employee may be returned to the TDP. (Refer to Executive Order 12564, section 5, paragraph (c), and DODD 1010.9, paragraph F2d.)

14-23. Specimen collection

The IBTC must meet all collection requirements prescribed by the DHHS's Mandatory Guidelines for Federal Workplace Drug Testing Programs. Collection procedures are provided in the "Urine Specimen Collection Handbook for Federal Workplace Drug Testing Programs." The collection handbook is available at Web Site: www.health.org/govpubs/PHD730/.

14-24. Medical review and reporting of DFW test results

- a. The medical review serves as a critical safeguard in the urine drug-testing program to ensure that positive drug tests resulting from legitimate medications and foods are not misinterpreted as illegal drug use. All laboratory results (positives and negatives) are forwarded to the MRO for review according to DHHS's Mandatory Guidelines for Federal Workplace Drug Testing Programs.
- b. General medical review and reporting procedures and instructions for the MRO are provided in paragraph 3-4, DA Pam 600-85.

14-25. Contractor requirements

Contractor requirements for a DFW are set forth in the Federal Acquisition Regulation, Subpart 23.5 as supplemented by the DoD in the Defense Federal Acquisition Regulation Supplement.

14-26. Additional Testing Designated Positions within the U.S. Army Corp of Engineers

The approved positions are as follow:

- a.* Positions that require the incumbent to operate any surface vessel, whether powered or not, including dredging equipment, in which the duties include operating, navigating, steering, directing, or sailing the vessel, operating the engines of a vessel while underway, or operating the spud(s) [anchor(s)] on a dredge.
- b.* Positions that require the incumbent to operate navigational locks for passage of marine surface traffic or that involve dispatching and clearing marine surface traffic in and out of narrow ship canals, to include marine traffic controllers.
- c.* Positions that require the incumbent to operate flood control gates to control water levels on waterways, to include dam operators.
- d.* Positions that require the incumbent to operate a water treatment plant to produce potable water for community and government use in which the duties include laboratory testing of water samples or the introduction of potentially hazardous chemicals and compounds into the water in the course of treatment.

Section V

DOT Drug and Alcohol Testing Program

14-27. Objectives

The DOT alcohol and other drug testing program is designed to help prevent accidents and injuries resulting from the misuse of alcohol or the use of controlled substances by drivers of commercial vehicles.

14-28. Applicability

Department of Transportation rules at 49 CFR, Part 382 apply to all DA employees in transportation who drive commercial motor vehicles in commerce in any state and are subject to the commercial driver's license requirements of 49 CFR Part 383. (Definitions of DOT words and phrases used in this regulation are provided at appendix B, DA Pam 600-85.)

14-29. Safety-sensitive functions

Department of Transportation rules apply to all on duty time that a driver performs any safety-sensitive function as defined in 49 CFR, Section 382.107. (Refer to para 4-2, DA Pam 600-85 for a list of safety-sensitive functions.)

14-30. DOT prohibited conduct and consequences

- a.* DOT prohibited conduct is listed in paragraph 4-3, DA Pam 600-85 and further described in 49 C.F.R. part 382, subpart B.
- b.* Consequences of prohibited conduct are listed in 49 CFR, Part 382, Subpart E. Drivers who engage in prohibited conduct must be immediately removed from safety-sensitive functions and cannot resume such duties unless they have met the requirements of 49.C.F.R. section 382.605. Additionally, supervisor/managers having actual knowledge that a violation has occurred are prohibited from permitting the driver to perform safety-sensitive functions. (DA Pam 600-85, para 4-3 for additional guidance regarding the consequences of engaging in prohibited conduct.)

14-31. Department of Transportation categories of testing

DA civilian drivers to whom DOT rules apply are subject to testing under circumstances described in 49 CFR, Part 382, Subpart C. These include the following six bases for alcohol and other drug testing: pre-employment testing; post-accident testing; reasonable suspicion testing; random testing; follow-up testing; and return-to-duty testing. While similar to the DFW drug testing categories listed in paragraph 14-18 of this regulation, DOT categories have different requirements. (DA Pam 600-85, para 4-4).

14-32. Department of Transportation testing procedures and required education and training

- a.* DA civilian drivers to whom DOT rules apply are subject to the testing procedures identified in 49 CFR, Part 40.
- b.* Department of Transportation rules require supervisory training and driver education. Requirements are in 49 CFR 382, Sections 382.601 and 382.603.

14-33. Department of Transportation frequency of random alcohol and other drug testing

Random testing of drivers will occur at the minimum rates of 25% annually for alcohol and 50% for controlled substances, which are adjustable by the FHWA. Each year the FHWA publishes in the Federal Register the minimum annual percentage rates for alcohol and other drug testing of drivers.

14-34. Specimen collection for DOT drug testing

The collector must successfully complete required training and have met all the collection requirements prescribed by DOT alcohol and other drug testing procedures and rules in 49 CFR, Part 40, Subpart B.

14–35. Medical review and the reporting of DOT drug test results

a. The medical review serves as a critical safeguard in the urine drug-testing program to ensure that positive drug tests resulting from legitimate medications and foods are not misinterpreted as illegal drug use. All laboratory results (positives and negatives) are forwarded to the MRO for review.

b. Qualifications, duties, and responsibilities of the MRO are contained in 49 CFR, Part 40. (DA Pam 600-85, para 4-6 contains medical review reporting procedures and additional instructions.)

14–36. Alcohol testing

The IBAT will have been trained to proficiency in the operation of the evidential breath testing and or the non-evidential breathe testing devices used at the installation and the alcohol testing procedure in 49 CFR, Part 40.

14–37. SAP evaluation, referral, and follow-up

The installation SAP will evaluate any employee/driver who has engaged in prohibited conduct associated with alcohol misuse and/or controlled substance (drug) abuse. If the SAP determines that the employee/driver needs assistance, the SAP will recommend a course of treatment and refer the individual to an appropriate treatment resource. Department of Transportation rules also require that such employees shall be subject to unannounced follow-up alcohol and drug testing. Evaluation, referral, and follow-up requirements are provided in 49 CFR, Section 382.605. Additional guidance is provided in the DOT Substance Abuse Professional Procedures for Transportation Workplace Drug and Alcohol Testing Programs, dated June 1995. (DA Pam 600-85, para 4-7 for instructions for the installation EAPC.)

14–38. DOT management information requirements

Reporting requirements are contained in paragraph 9-4 of this regulation. The information required is specified in 49 CFR, Section 382.403. Additionally, the ADCO or the EAPC will document BAT training and proficiency.

Appendix A

References and Terms

Section I

Required Publications

AR 40–66

Medical Record Administration (Cited in para 3-7b, 6-6b, 6-6c, 9-5, 14-15e.)

AR 40–501

Standards of Medical Fitness (Cited in para 7-6b.)

AR 50–5

Nuclear Surety (Cited in para 6-6e, 14-21a(8).)

AR 50–6

Chemical Surety Personnel Reliability Program (Cited in para 6-6e, 14-21a(8).)

AR 135–175

Separation of Officers (Cited in paras, 12-15a(2)(d), 13-10a(3)(a), 13-12a(2)(c).)

AR 135–178

Separation of Enlisted Personnel (Cited in paras 12-15a(2)(d), 13-10a(3)(b), 13-12a(2)(c).)

AR 140–158

Enlisted Personnel Classification, Promotion, and Reduction (Cited in para 13-10d(4)(a).)

AR 190–22

Searches, Seizures and Disposition of Property (Cited in para 3-7a(5).)

AR 195–2

Criminal Investigation Activities (Cited in para 1-15b(2).)

AR 215–1

Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities (Cited in para 1-33a.)

AR 340–21

The Army Privacy Program (Cited in para 6-6b.)

AR 600–8–2

Suspension of Favorable Personnel Actions (Flags) (Cited para 5-7.)

AR 600–8–24

Officer Transfers and Discharges (Cited in paras 1-35a(3), 3-2c, 5-5, 6-4d, 6-5.)

AR 614–5

Stabilization of Tours (Cited in para 4-11b.)

AR 614–30

Overseas Service (Cited in para 4-11b.)

AR 635–200

Enlisted Personnel (Cited in para 1-35a(3), 3-10d, 4-13b, 5-5, 6-3f, 6-4d.)

NGR 500–2

National Guard Counterdrug Support Regulation (Cited in para 12-19a.)

DA Pam 600–85

Army Substance Abuse Program (Cited throughout chap 14.)

DOD Directive 1010.4

Drug and Alcohol Abuse by DOD Personnel (Cited in para 1-29a.)

DOD Directive 1010.9

DOD Civilian Employee Drug Abuse Testing Program (Cited in para 14-23.)

DOD Instruction 1010.16

Technical Procedures for Military Personnel Drug Abuse Testing Program (Cited in para 8-4g.)

Mandatory Guidelines for Federal Workplace Drug Testing Programs, published by DHHS, which includes Scientific and Technical Requirements and Certification of Laboratories Engaged in Urine Drug Testing, 53 Fed. Reg. 11970 (1988) as amended by 59 Fed. Reg. 29908 (1994)

Urine Specimen Collection Handbook for Federal Workplace Drug Testing Programs, Division of Workplace Programs, Center for Substance Abuse and Mental Health Services Administration, the U.S. Department of Health and Human Services (Cited in para 14-23.)

Executive Order 12564, Drug-free Federal Workplace, September 15, 1986 (Cited in para 14-18, 14-20a, 14-22d.)

Section II**Related Publications****AR 1–35**

Basic Policies and Principles for Interservice, Interdepartmental and Interagency Support

AR 40–48

Nonphysician Health Care Providers

AR 40–68

Quality Assurance Administration

AR 190–5

Motor Vehicle Traffic Supervision

AR 190–22

Searches, Seizures, and Disposition of Property

AR 190–30

Military Police Investigations

AR 195–2

Criminal Investigation Activities

AR 360–1

The Army Public Affairs Program

AR 380–67

The Department of the Army Personnel Security Program

AR 600–8–1

Army Casualty Operations/Assistance/Insurance

AR 600–105

Aviation Service of Rated Army Officers

AR 601–280

Army Retention Program

AR 623–105

Officer Evaluation Reporting System

AR 623–205

Noncommissioned Officer Evaluation Reporting System

AR 635–5

Separation Documents

DOD Directive 1010.1

Military Personnel Drug Abuse Testing Program

DOD Directive 1010.9

DOD Civilian Employee Drug Abuse Testing Program

DOD Directive 6025.13

Clinical Quality Management Program (CQMP) in the Military Health Services System

DOD Instruction 4000.19

Interservice and Intragovernment Support

NGR (AR) 600–5

The Active Guard Reserve (AGR), Title 32

NGR (AR) 600–200

Enlisted Personnel Management

Title 5 CFR, Part 752, Adverse Actions

Title 5 USC, “The Privacy Act,” Sections 75, 552(a), 7301, (1987, and 8331 (20))

Title 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and 42 USC 290dd-2, Confidentiality of Records

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, PL 91-616

Drug Abuse Office and Treatment Act of 1972, PL 92-255

Civil Service Reform Act of 1978, PL 95-454

Federal Employees Substance Abuse Education and Treatment Act of 1986, title VI of PL 99-570

Supplemental Appropriations Act, 1987, PL 100-71, 503, 5 USC 7301 note

Drug-free Workplace Act of 1988, Subtitle D of the Anti-drug Abuse Act, PL 100-690

Omnibus Transportation Employee Testing Act of 1991, title V of PL 102-143

FAR 23.223-5, 23.223-6 and 52.223-5

ADAPT Manual, Army Center for Substance Abuse

Section III**Prescribed Forms**

None required for this section. (Prescribed forms transferred to DA Pam 600-85.)

Section IV**Referenced Forms****DA Form 11–2–R**

Management Control Evaluation Certification Statement

DA Form 268

Report to Suspend Favorable Personnel Actions

DA Form 3711

Alcohol and Drug Abuse Prevention and Control Program Resource and Performance Review (RAPR)

DA Form 3881

Rights Warning Procedure/Waiver Certificate

DA Form 3997

Military Police Desk Blotter

DA Form 4465

Patient Intake/Screening Record

DA Form 4466

Patient Progress Record

DA Form 4856

General Counseling Form

DA Form 5019

Condition(s) of Employment for Certain Civilian Positions Identified as Critical under the Department of the Army Drug-free Federal Workplace Program

DA Form 7412

Condition(s) of Employment for Certain Civilian Positions Identified Safety Sensitive under the Department of Transportation, Federal, Highway Administration Rules on Drug and Alcohol Testing

DA Form 8003

Alcohol and Drug Abuse Prevention and Control Program

DD Form 2624

Specimen Custody Document-Drug Testing

FHWA MCS-154 (Rev. 1-94)

FHWA Drug and Alcohol Testing Management Information System Data Collection Form

FHWA MCS-155 (Rev. 1-94)

FHWA Drug and Alcohol Testing Management Information System "EZ" Data Collection Form

SF 513

Medical Record-Consultation Sheet

SF 600

Health Record-Chronological Record of Medical Care

SF 702

Security Container Check Sheet

Appendix B**Unit Commander's guide to the Army Substance Abuse Program (ASAP)**

This guide provides basic information to unit commanders of active Army organizations about the Army Substance Abuse Program (ASAP). The following questions and figures provide a quick reference of the unit commander's responsibilities, resources, and procedures necessary to participate in and fully support the ASAP prescribed by AR 600-85.

B-1. What is the Army Substance Abuse Program?

Response 1: The Army Substance Abuse Program, or ASAP, is a comprehensive program which combines deterrence,

prevention, and treatment designed to strengthen the overall fitness and effectiveness of the Army and to enhance the combat readiness of its personnel and units by eliminating alcohol and/or other drug abuse. (ASAP mission and objectives are listed in para 1-30, AR 600-85.)

B-2. What is the unit commander's role in the ASAP?

Response 2: Unit commanders must observe their soldiers' behavior and intervene early to identify possible alcohol and/or other drug abusers, refer these soldiers for evaluation by trained medical personnel, recommend enrollment in treatment programs, and when appropriate, process soldiers for separation. (More information on the unit commander's role in ASAP can be found in para 1-31, AR 600-85.)

B-3. What specifically must the unit commander do?

Response 3: There are basically three major actions a unit commander must accomplish: First, an organizational team must be appointed to conduct the unit's ASAP activities; second, a unit biochemical testing program must be established; and third, prevention and education initiatives must be implemented. (A list of the unit commander's responsibilities is contained in para 1-26, AR 600-85.)

a. The unit commander must appoint a Unit Prevention Leader (UPL) to design and implement the unit prevention plan, administer the unit biochemical testing program, and keep the commander informed of trends in alcohol and other drug abuse in the unit. (See para 1-27, AR 600-85 for a detailed list of UPL responsibilities.)

b. The biochemical-testing program facilitates early identification of alcohol and/or other drug abuse in the unit and enables commanders to assess the security, military fitness, and good order and discipline of their units. Commanders work with the installation Alcohol and Drug Control Officer (ADCO) (See response 5a below) to test soldiers at the rate of one random sample per soldier per year. (See chap 8, AR 600-85 for more information on biochemical testing.)

c. Unit commanders must take measures that deter and reduce the abuse or misuse of alcohol and other drugs to the lowest extent possible through education, community involvement, and deglamorization of alcohol. (See Response 4 and chap 2, AR 600-85 for information on prevention policies and strategies.)

B-4. What are the keys to ASAP success?

Response 4: Actions taken to prevent, deter, and reduce alcohol and other drug abuses are the keys to ASAP success. At each post or installation, the ADCO will develop an Installation Prevention Plan, which the unit commander can access for information, programs, and ideas. While there are many forms of prevention strategies available, unit commanders should provide education and training to soldiers on the effects and consequences of alcohol and other drug abuse, along with the treatment services which are available at the installation. Commanders must also take steps to deglamorize alcohol and ensure that alcohol is never the focus of any unit event. (Chap 2, AR 600-85 contains prevention strategies available to the commander.)

B-5. What assets outside the organization does the unit commander have to assist in ASAP activities?

Response 5: ASAP is a command program with numerous resources available to assist the commander. These include:

a. The Installation Alcohol and Drug Control Officer (ADCO). The ADCO provides the unit commander with ASAP consultation to assist in the identification and referral of individuals suspected of alcohol and/or other drug abuse. (See para 1-17, AR 600-85 for a complete list of ADCO responsibilities.)

b. The Installation Prevention Coordinator (PC). The PC promotes ASAP services, provides prevention education services, and oversees the training of UPLs (See Response 3a above). (See para 1-18, AR 600-85 for a complete list of PC responsibilities.)

c. Clinical Services. The local ASAP Counseling Center provides the unit commander with a wide range of clinicians to screen, evaluate, and treat alcohol and/or other drug abusers.

B-6. What process should be followed if a unit commander suspects a soldier of alcohol and/or other drug abuse?

Response 6: Figure B-1 provides an outline of the process. If a unit commander has some reasonable suspicion (the chain of command has noticed unusual or aberrant behavior by the soldier), but not sufficient evidence for probable cause to suspect a soldier of drug or alcohol abuse, and if the unit commander believes the Limited Use Policy applies, the unit commander should consult with the ADCO and supporting legal advisor before discussing the Limited Use Policy with the soldier. If appropriate, the unit commander may then explain the Limited Use Policy to the soldier. If a unit commander has probable cause to suspect a soldier of drug or alcohol abuse (the chain of command has noticed unusual or aberrant behavior by the soldier) and there is sufficient additional corroboration, the commander should consult with the supporting legal advisor and if appropriate advise the suspect of their rights under UCMJ Article 31(b) using DA Form 3881, Rights Warning/Waiver Certificate. If the Soldier waives his rights the commander may then question the soldier about alcohol or drug abuse, If there is less than probable cause, the commander may still refer the

soldier for professional evaluation by ASAP clinical personnel or the commander may decide that the soldier should simply be returned to duty.

B-7. What does the unit commander do when notified that a soldier has registered a positive drug test?

Response 7: Figure B-2 provides an outline of the process. When a unit commander is notified that a soldier was reported positive for a drug test (for example, as a result of a random urinalysis), the unit commander's actions are determined by the type of drug identified. If the drug does not have a legitimate medical use as determined by USAMEDCOM, the commander will consult with law enforcement to determine whether law enforcement desires to conduct an investigation. The commander will also flag the soldier and consult with the trial counsel who supports the unit. If law enforcement declines to conduct an investigation, the commander must conduct his or her own preliminary inquiry into the alleged offense. The commander must advise the soldier of his or her legal rights under UCMJ Article 31 (b) using DA Form 3881, Rights Warning Procedure/Waiver Certificate. If the soldier waives his or her rights, the commander may then question the soldier about drug abuse. After completing the inquiry or investigation the commander should consider the full range of actions in accordance with the R.C.M. 306 of the MCM. The commander shall also comply with the requirements of para.14-12(d)-(f), AR 635-200. The commander may initiate action under the UCMJ and start administrative separation processing simultaneously. Regardless of the action taken, the soldier must be referred to the ASAP.

B-8. What can I expect when a soldier is enrolled ASAP treatment?

Response 8: When the soldier is enrolled in ASAP, both the commander and the soldier must dedicate time and effort to the process. Depending on the severity of abuse, the treatment plan may include the soldier's participation in any/all of the following:

- a. At least 12 hours of alcohol and other drug abuse training (ADAPT).
- b. Weekly individual or group counseling sessions.
- c. A 2 to 4 week partial inpatient care program.
- d. Attendance at self-help groups such as Alcoholics Anonymous or Narcotics Anonymous.
- e. Rehabilitation drug testing.

Note. Unless hospitalized, the soldier is expected to participate in normal unit operations (for example, field training exercises, CQ or similar duties, and deployments) while receiving the care listed above.

B-9. The commander's participation is critical to the success of the rehabilitation process.

The commander will—

- a. Evaluate and provide periodic feedback to the counselor about the soldier's duty performance during care.
- b. Review ongoing evaluations of the soldier's progress and participation provided by the ASAP counselor and meet with the soldier to discuss the evaluation.
- c. Participate in Rehabilitation Team meetings with the ASAP clinical staff. (Chap 4 of AR 600-85 addresses the rehabilitation process.)
- c. Make the final determination of the success or failure of the soldier's rehabilitation (normally within 3 to 6 months of initial enrollment).

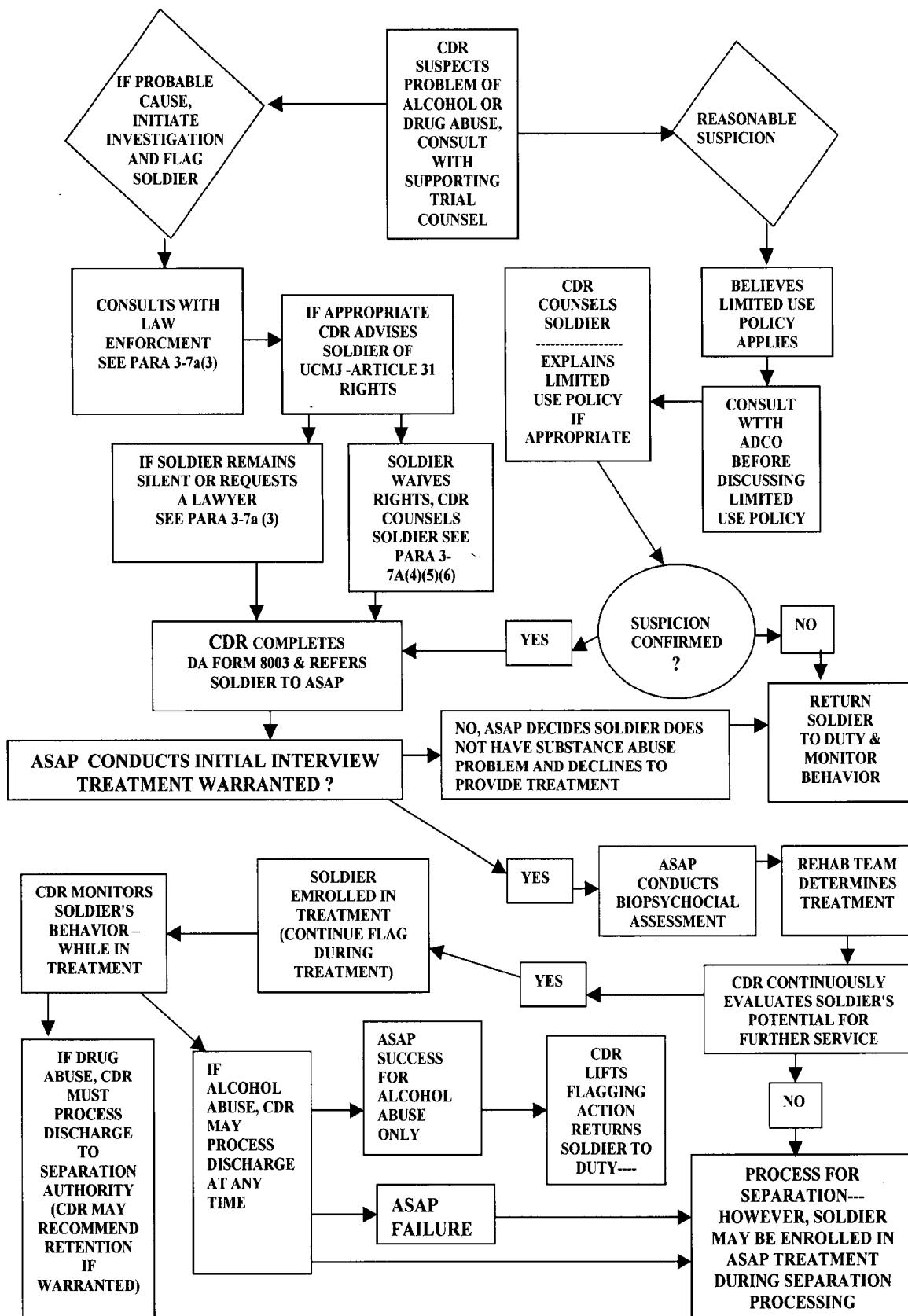


Figure B-1. Alcohol and/or other drug abuse process.

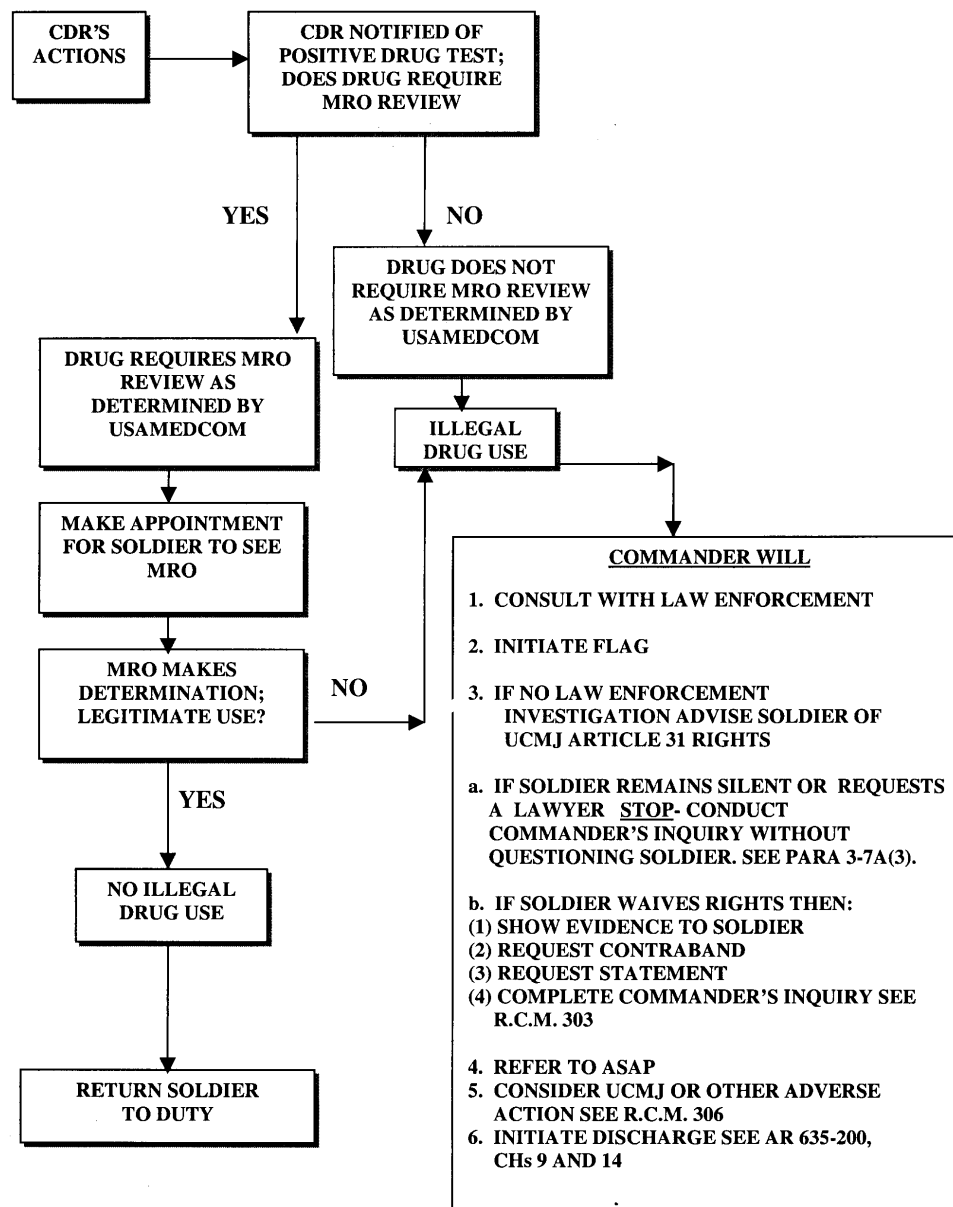


Figure B-2. Positive drug test process.

Appendix C

MANAGEMENT CONTROL EVALUATION CHECKLIST

C-1. Function

The function covered by this checklist is the administration of the Army Substance Abuse Program (ASAP).

C-2. Purpose

The purpose of this checklist is to assist assessable unit managers and Alcohol and Drug Control Officers (ADCOs) in evaluating the ASAP as outlined below.

C-3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement). A copy of DA Form 11-2-R is available on the Army Electronic Library CD-ROM (EM0001) and on the USAPA web site (www.usapa.army.mil). Additional questions at Appendix F should be considered when evaluating ASAP program.

C-4. Test Questions

- a.* Is an ADCO position authorized on the Table of Distribution and Allowances and filled full time to implement the ASAP?
- b.* Are new commanders briefed on the ASAP upon assuming command?
- c.* Have unit alcohol and drug coordinators been identified and trained?
- d.* Is there an Installation Biochemical Testing Coordinator (IBTC) and alternate IBTC appointed on orders signed by the ADCO and have they attended and passed the Army Center for Substance Abuse Programs IBTC Course?
- e.* Is there a written collection Standard Operating Procedures (SOP)?
- f.* Is there a notification procedure for military personnel that includes the commander sending laboratory positives for amphetamines, barbiturates, or opiates to the MRO for final determination of legitimate use versus non-prescribed?
- g.* Are commanders conducting unannounced drug testing?
- h.* Is there an active DA civilian employee drug testing program and has a DA Form 5019 (Condition(s) of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program) and/or a DA Form 7412 (Condition(s) of Employment for Certain Civilian Positions Covered under the Department of Transportation Rules on Drug and Alcohol Testing) been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
- i.* Has the ADCO developed and implemented a plan to access and monitor command utilization of and satisfaction with all aspects of the program (that is, prevention, identification, rehabilitation, and treatment)?
- j.* Has the ADCO developed and implemented a prevention education program that coordinates and tracks substance abuse prevention efforts for soldiers?

C-5. Suppression

This checklist replaces the checklist for the Alcohol/Drug Program previously published in DA Circular 11-89-1.

C-6. Comments

Submit comments to: Director, ACSAP, 4501 Ford Avenue, Suite 320, Alexandria, VA 22302-1460.

Appendix D

PROGRAM EVALUATION TEST QUESTIONS

D-1. Objective

The objective of these test questions is to assist unit managers and Alcohol and Drug Control Officers (ADCOs) in evaluating the ASAP.

D-2. Test Questions for Prevention of Abuse

- a.* Is an ADCO position authorized on the TDA and filled full-time to implement the ASAP?
- b.* Are elements of prevention included in the ADCO position description?
- c.* Are the following essential prevention activities fully functional? (Note: Prevention activities are based on an installation's needs assessment.)
 - (1) Educating commanders about the ASAP?
 - (2) ASAP professional staff development?
 - (3) Civilian employee ASAP education?
 - (4) Family member ASAP education?
 - (5) Community awareness education on the ASAP?
 - (6) Unit education programs on the ASAP?
- (7) Is Alcohol and Drug Abuse Prevention Training (ADAPT) implemented in accordance with AR 600-85 and ACSAP standards?
- (8) Is ADAPT offered a minimum of once monthly?

D-3. ASAP Operations

- a.* Does the ADCO brief the Installation Commander on the overall ASAP status quarterly?
- b.* Are new commanders briefed on the ASAP upon assuming command?
- c.* Have unit alcohol and drug coordinators received training during the last year?
- d.* Have alcohol/drug articles been published (or radio/television/ electronic media announcements made) to support and inform on the ASAP and its programs?
- e.* Were prevention campaigns conducted, such as Drunk and Drugged Driving Awareness and Red Ribbon?

D-4. Identification of Abuse

- a.* Is the Medical Review Officer (MRO) appointed on orders signed by the Medical Treatment Facility (MTF) commander?
- b.* Has the MRO attended formal MRO training?
- c.* Is there an Installation Biochemical Testing Coordinator (IBTC) and alternate IBTC appointed on orders signed by the ADCO?
- d.* Have the IBTC and alternate IBTC attended and passed the ACSAP IBTC Course?
- e.* Is there a written collection SOP?
- f.* Is there a written SOP that covers IBTC administrative and operational procedures?
- g.* Has the ASAP evidence storage area passed a physical security inspection within the past year?
- h.* Are unit collections for all units inspected a minimum of twice annually by the IBTC or designee?
- i.* Is there a notification procedure for military personnel that includes the commander sending laboratory positives for amphetamines, barbiturates, or opiates to the MRO for final determination of legitimate use versus nonprescribed?
- j.* Are all patients identified through medical channels as having a drug or alcohol related diagnosis or related incident resulting in medical treatment referred to the ASAP?
- k.* Are appropriate reports (MP blotters, Serious Incident Reports) reviewed on a daily/weekly basis?
- l.* Are rehabilitation clients being periodically drug tested through the ASAP?
- m.* Are rehabilitation drug test properly coded on the chain of custody form?
- n.* Are copies of DA Form 4465 (Patient Intake/Screening Record (PIR)), DA Form 4466 (Patient Progress Report (PPR)); and data for completion of DA Form 3711 (Alcohol and Drug Abuse Prevention and Control Program Resource and Performance Report (RAPR)) provided to the ADCO by the clinical staff?
 - o.* Are DA Forms 4465, 4466, and 3711 completed and forwarded to ACSAP?
 - p.* Is there an active DA civilian employee drug testing program?
 - q.* Has a DA Form 5019 (Condition(s) of Employment for Certain Civilian Positions Identified as Critical Under the Drug Abuse Testing Program) and/or a DA Form 7412 (Condition(s) of Employment for Certain Civilian Positions Covered under the Department of Transportation Rules on Drug and Alcohol Testing) been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
 - r.* Are all supervisors trained at least annually on techniques for identifying abusers, the dangers of "enabling" and the referral process?
 - s.* Are commanders conducting unannounced drug testing?
 - t.* Have commanders been trained in "smart testing" techniques?

D-5. Rehabilitation and Treatment (to be completed by the Clinical Director)

- a.* Are face-to-face rehabilitation team meetings conducted with commanders for each soldier screened?

- b.* Have effective procedures been developed and implemented to ensure that the original of DA Forms 4465 and 4466 are forwarded to ACSAP?
- c.* Have effective procedures been developed and implemented to ensure that the ADCO is provided a copy of all DA Forms 4465 and 4466?
- d.* Have effective procedures been developed and implemented to ensure that the ADCO is provided all data required for completion of the DA Form 3711?
- e.* Have effective procedures been developed and implemented to ensure that rehabilitation urine testing is accomplished on all soldiers enrolled in the ASAP?
- f.* Has an effective monitoring procedure been implemented to ensure that results of all rehabilitation urine testing are provided to the appropriate counselor?
- g.* Has an effective monitoring procedure been implemented to ensure that open file cases on soldiers who are in a permanent change of station status are forwarded to the gaining ASAP?
- h.* Does ASAP check with ACSAP for prior enrollment information on soldiers currently evaluated and/or enrolled?
- i.* Is a DA Form 4466 completed and forwarded to ACSAP for each soldier in a PCS loss or gain status?
- j.* Have effective procedures been implemented to ensure that the ADCO is provided a copy of this rehabilitation and treatment review?

D-6. Program Evaluation

- a.* Have local statistics been maintained and analyzed for program needs and trends?
- b.* Has an Alcohol and Drug Intervention Council (ADIC) or similar forum been established to review current installation issues and trends?
- c.* Does the ADIC meet, at a minimum, on a quarterly basis?
- d.* Are “pre” and “post” tests utilized for ADAPT to assist in determining effectiveness of training?
- e.* Are evaluation forms on course content used for all training?
- f.* Are instructor evaluation forms used for all presentations?
- g.* Has the Federal Drug-free Workplace Program Report been submitted to ACSAP to provide statistical information on the civilian (DFW) drug testing program?
- h.* Is the Office of Personnel Management (OPM) Federal Employee Counseling Program Report prepared and forwarded to HQDA annually?
- i.* Have monthly reports been submitted on DA Form 3711-R to ACSAP to provide statistical status on the ASAP?
- j.* Have goals and objectives been formulated in a written plan for a comprehensive installation prevention plan?
- k.* Is the ADCO provided a copy of the internal rehabilitation and treatment review?
- l.* Has the ADCO developed and implemented a plan to access and monitor command utilization of and satisfaction with all aspects of the program (that is, prevention, identification, rehabilitation, and treatment)?

Appendix E

Standing Operating Procedures (SOP) For Urinalysis Collection, Processing and Shipping

E-1. General

This SOP provides guidance and standardizes urinalysis collections throughout the United States Army. (The IBTC Guidebook and Commanders Guide and UPL Urinalysis Collection Handbook contain additional guidance and Department of the Army requirements. These handbooks are designed to assist the unit commander, UPL and IBTC by providing detailed information on collection, handling, processing and shipping procedures for urine specimens.)

E-2. Applicability

This SOP is applicable to all urinalysis collections conducted on active duty, National Guard, and Army Reserve soldiers. This includes all types of collections listed in chapter 8 of this regulation.

E-3. Related Material

ACSAP Commanders Guide and UPL Urinalysis Collection Handbook, ACSAP IBTC Guidebook and DOD Instruction 1010.16 Technical Procedures for Military Personnel Drug Abuse Testing Program.

E-4. Pre-Collection Procedures

- a.* The unit commander directs that a urine test be conducted and identifies individual soldiers, parts of unit, and/or entire unit for testing.
- b.* UPL obtains supplies for testing:
 - (1) DoD prescribed Urine specimen collection bottles with boxes.

- (2) Optional wide mouth collection cup (for females).
- (3) Tamper evident tape.
- (4) Bottle labels.
- (5) Unit ledger.
- (6) DD Form 2624 (Budget (Army Stock Fund) Fuel Data).
- (7) Disposable rubber gloves.
- c. Personnel to be tested are notified. Notification should take place preferably less than 2 hours, but no more than 6 hours, prior to reporting time.
- d. Commander selects Observers, E-5 or above, of the same sex as soldier being tested, (UPL will brief observers on their duties and responsibilities) and a holding area NCO/Officer, E-5 or above, to maintain control of personnel waiting to be tested.
- e. UPL will brief observers on their duties and responsibilities.
- f. A holding area for soldiers waiting to render a urine specimen is designated, an NCO/Officer, E-5 or above, is appointed to maintain control of personnel waiting to be tested.

E-5. Collection Procedures

- a. UPL puts on the disposable rubber gloves.
- b. Soldier approaches the UPL station with military identification Card (DD FORM 2.) when prepared to give a urine specimen. An alternate reliable method for verifying the SSN of the soldier is required, if the soldier does not have a DD Form 2 in his/her possession.
- c. Soldier will remove excess outer garments such as BDU Jackets, coats, or sweat tops.
- d. UPL initiates all required paperwork (if pre-prepared forms and labels are used the UPL will verify all information with the military ID Card). If a clerical mistake is made while filling out entries; on the DD Form 2624, on the bottle label, or the unit ledger prior to the discrepancy inspection required by the IBTC, the mistake may be corrected by its maker by lining through (single line) the mistake, initialing and dating the correct entry. No other method of correction is authorized except by memorandum, titled "Certificate of Correction," as described in paragraph E-7b.
 - (1) UPL prepares label with the following information:
 - (a) Date (YYYYMMDD)
 - (b) Base/area code
 - (c) Soldier's SSN
 - (2) UPL prepares a DD Form 2624 with the following information. (For specific guidance on completing the DD Form 2624, see the Commanders Guide and UPL Urinalysis Collection Handbook). If less than 12 specimens are collected then leave the remaining blocks blank.
 - (a) Blocks 1-6.
 - (b) Soldier's SSN (block 8).
 - (c) Test Basis (block 9).
 - (d) Test Information (block 10).
 - (3) UPL prepares the unit ledger with the following information (For specific guidance on completing the unit ledger, see the Commanders Guide and UPL Urinalysis Collection Handbook):
 - (a) Calendar Date.
 - (b) Batch and Specimen number (blocks 5 and 7 from DD Form 2624).
 - (c) Soldier's printed name (Soldier will sign later).
 - (d) Soldier's SSN.
 - (e) Soldier's Rank.
 - (f) Test basis.
 - (g) Printed Name of Observer (Observer will sign later).
 - (h) Remarks.
- e. The UPL directs the soldier to verify the information on the bottle label, unit ledger, and DD Form 2624. The soldier will then initial the bottle label. His/her initials are verification that all data is correct.
- f. The UPL will remove a new collection bottle from the box in front of the soldier and replace it with the soldier's military ID Card. The UPL will then affix the label to the bottle, in full view of both the soldier and the observer, and hand it to the soldier.
- g. The soldier will ensure that the observer has full view of the bottle at all times until the UPL takes custody of the specimen. At no time will the observer take custody of the urine specimen.
- h. If the soldier is female the optional wide mouth collection cup will be issued to the soldier at this time.
- i. The soldier and observer will move to a secure latrine, the bottle will be held by the soldier above his/her shoulder as to keep it in full view of the observer. The observer will keep the collection bottle in sight at all times.

j. Once in the latrine, the observer will direct the soldier to wash his/her hands without the use of soap. The soldier will then move to the appropriate facility to collect the specimen.

k. The soldier will remove the cap of the bottle in full view of the observer, and will hold it or place it face up on a clean surface. The bottle and cap must be in full view of the observer.

l. The soldier will then fill the bottle with at least 30 mL of urine (approximately half the specimen bottle). The observer MUST SEE urine leaving the body and entering the bottle. The soldier will recap the bottle in full view of the observer.

m. The following procedure applies to female soldiers who utilize the wide mouth collection cup:

(1) The soldier will remove the cap from the collection cup, and provide the specimen. The observer will keep the collection cup and the bottle in full view and directly observe urine leaving the body and entering the cup.

(2) The soldier will then open the specimen bottle, and pour the urine from the cup into the bottle. The soldier will recap the bottle in full view of the observer. The observer will watch this entire procedure. The bottle must contain at least 30 mL of urine.

Note. If less than 30 mL of urine is collected, the entire specimen and the bottle will be destroyed. The soldier will be sent back to the holding area until he/she can provide a full specimen. Procedure will begin at step E-5b, original entries on the DD Form 2624 and unit ledger may be utilized for the second specimen collected.

n. The soldier may wash his/her hands with soap after recapping the specimen as described in steps l and m above, but the soldier and observer must keep the specimen in full view.

o. The observer and the soldier will return to the UPL's station. The soldier will walk in front with the bottle held above his/her shoulder. The observer will keep the bottle in sight at all times.

p. The soldier will hand the bottle containing his/her specimen to the UPL; both the soldier and observer will continue to keep the bottle in sight at all times until the UPL places the specimen in the collection box.

q. The UPL will take the bottle, verify that the cap is secure, and inspect the specimen for possible adulteration. If adulteration is suspected, the UPL will secure the specimen and order the soldier to stand fast and, ensure that the commander is notified.

r. The UPL will then place tamper evident tape across the bottle cap. The tape will be one continuous piece that touches the label on both ends without obscuring any information, running across the top of the bottle.

s. The UPL will then initial the bottle label. The UPL's initials signifies that he/she has received the specimen from the soldier, checked the specimen for adulteration, ensured the cap was secure, and placed tamper evident tape across the cap.

t. The UPL will place the specimen in the collection box, removing the soldier's ID card.

u. The observer will then sign the unit ledger in front of the UPL and soldier to verify he/she complied with the collection process and directly observed the soldier provide the sample and maintained eye contact with the specimen until it was placed in the collection box.

v. The soldier will then sign the unit ledger in front of both the observer and UPL verifying that he/she provided the urine in the specimen bottle and that he/she observed the specimen being sealed with tamper evident tape and placed into the collection box.

w. The ID card will be returned to the soldier at this time, and he/she is released from testing.

E-6. Post-Collection Procedures

After all specimens have been collected the UPL will:

a. Verify that all SSNs on the unit ledger, DD Form 2624 and bottle labels match.

b. Ensure that all required information, signatures, and initials are on the bottle label, unit ledgers, and DD Form 2624.

c. Place each DD Forms 2624 into the corresponding specimen container(s).

d. Will transport all specimens to the Installation Biochemical Collection Point (IBCP) as soon as possible (normally the same duty day).

e. If unable to transport to the IBCP immediately, the specimens, DD Forms 2624, and unit ledgers will be placed into temporary storage, as described in paragraph E-10.

E-7. Receipt of Specimens at IBCP:

a. At the IBCP, the unsealed specimen containers will be opened by the IBTC or the IBTC's designated representative. The actions of the IBTC outlined below may be performed by the IBTC's designated representative. If there is no IBTC, the actions will be performed by the person designated by the ADCO or MACOM ADCO. The IBTC will:

(1) Review the DD Forms 2624, unit ledger and bottle labels for completeness. He/she will ensure that the information contained on the front side of the DD Form 2624 is correct and corresponds with the information on the bottle label:

(a) Complete address of submitting unit.

(b) Base/area code.

- (c) Social Security Number.
 - (d) Test Basis (Correct code for the type of urinalysis i.e. command directed, inspection, medical, rehabilitation).
 - (e) Test Information.
 - (f) Initials of UPL and soldier.
 - (g) Date Specimens Collected.
- (2) Ensure that, at a minimum 30 mL of urine is contained in each bottle and that an unbroken piece of tamper evident tape is correctly placed on each bottle.
- (3) Ensure the chain of custody portion of the DD Form 2624 is complete and accurate. Specific issues he/she should address are:
- (a) Signatures accounting for any change of custody are properly annotated.
 - (b) Correct dates.
 - (c) The "Purpose of change/remarks" column clearly explains each change of custody.
- b. If a discrepancy is found during the check, the IBTC shall initiate appropriate action to correct the discrepancy or error, if possible. All discrepancies that can be corrected must be explained in a memorandum titled, "Certificate of Correction," which explains:
- (1) The discrepancy.
 - (2) The circumstances.
 - (3) The corrective action taken.
- (a) All personnel involved including the person(s) who made the error and the IBTC must sign this certificate.
- (b) If the error is a missed entry or an incorrect entry either on the bottle label or on the DD Form 2624, corrections will not be made on the label or on the form. The evidence that a correction was made will be the memorandum titled, "Certificate of Correction."
- (c) The memorandum titled "Certificate of Correction," will be appended to the original and all copies of the DD Form 2624. The memorandum titled "Certificate of Correction," will be attached to the IBTC's DD Form 2624 until destruction date.
- c. If no discrepancies are noted, or all discrepancies have been corrected with a memorandum titled "Certificate of Correction," the UPL will enter:
- (1) The date the specimens were delivered in block 12a
 - (2) Print his/her name and sign their payroll signature in block 12b
 - (3) Print "Specimens released by UPL to IBTC" in block 12d
 - (4) Ensure that the IBTC prints and signs their payroll signature in block 12c to document receipt of the specimens.
- d. After the DD Form 2624 is completed it will be placed in a business size envelope.
- e. Liquid absorbent pads will be placed in each specimen box (containing up to 12 specimens) to absorb any leakage that may occur. Either the UPL or the IBTC may complete this step. The specimen box will be sealed with adhesive tape over all open sides, edges and flaps. The UPL or the IBTC then signs his or her payroll signature across the tape on the top and bottom of each container, and secures the envelope, with DD Form 2624 enclosed, unsealed, to the outside of the specimen container.

E-8. Shipping to the FTDTL

- a. All urine specimens will be forwarded to the supporting FTDTL.
- b. If the IBTC is going to ship the specimens to the FTDTL on the day received from the UPL then he/she will:
 - (1) Sign each DD form 2624 releasing it to one of the authorized modes of transportation, such as, "Released to Registered mail, Reg No. 123456."
 - (2) Prepare the specimen boxes as required for shipment.
- (a) All specimen containers will be wrapped for shipping.
- (b) Ensure that each DD Form 2624 remains inside an envelope taped to the specimen container.
- (c) Place specimen container inside a leak proof bag.
- (d) Wrap the container according to your carrier's requirements.
- (3) Ship containers to the drug testing laboratory by transportation priority one. One of the following transportation modes will be used:
 - (a) Registered mail.
 - (b) US Postal Service by First Class Mail.
 - (c) Hand-carried by surface transportation.
 - (d) Military aircraft transportation system.
 - (e) US flag commercial air freight, air express, and air freight forwarder.
 - (f) When none of the above satisfies the movement required, by foreign flag air carrier.
- c. If the IBTC is unable to ship the specimens until the next duty day, the specimens must be placed in temporary storage. The area must be a limited access area. The facility will meet the physical security requirements for evidence

storage as described in paragraph E-9. This will include an annual physical security evaluation by qualified personnel, an access roster, and an access log to annotate all personnel entering the limited access area.

E-9. Temporary Storage of Urine Specimens at the IBCP

The following describe the minimum requirements for temporary storage of urine specimen at the installation level, this is the preferred site for temporary storage.

a. Windows to the specimen storage room that are accessible from the exterior of the room will be covered with steel or iron bars or steel mesh as follows:

(1) When bars are used, they will be at least 3/8-inch thick and vertical bars will not be more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so those openings do not exceed 32 square inches. Ends of the bars will be securely embedded in the wall or welded to a steel channel frame fastened securely to the window casing.

(2) Acceptable steel mesh made from high carbon manganese steel, no less than 15/100-inch thick, with a grid of not more than 2-inches from center to center. 6-gauge steel mesh with a 2-inch diamond grid may be used when high carbon manganese steel is not readily available. The steel mesh will be welded or secured to a steel channel frame and fastened to the building by smooth headed bolts that go through the entire window casing. It will be spot welded or branded on the interior, or cemented into the structure itself to prevent easy forced entry.

(3) Air conditioners may be installed in windows or outside walls provided equivalent security measures are taken.

b. Doorways: There must be only one doorway that allows access to and from the specimen storage room.

c. Additional Requirements:

(1) Method 1- allows specimens to be stored inside the interior of the room, when not in full view of person who has custody.

(a) Construction: Walls must extend from the floor to the ceiling. Walls and ceilings may be made of masonry or wood. Walls or ceiling that are of wooden stud construction must have a combined exterior and interior thickness of at least 1-inch. Permanently installed flooring (other than masonry) may be used, if the floor cannot be breached without causing considerable damage to the building structure.

(b) Entrance into the room will require opening two successive doors.

(c) When an interior steel mesh cage is used, the door to the cage will serve as the second door. In this case, the outer door will be of solid core wood or metal.

(d) When a steel mesh cage is not used two doors hung one behind the other will be used. One door may be of steel mesh welded to a steel frame. The second door may be of solid core wood or steel; or it may be a hollow wooden door with the exterior reinforced with a steel plate not less than 1/8-inch thick.

(e) If a barred door is used, the vertical steel bars will be at least 3/8-inch thick and spaced no more than 4-inches apart. Horizontal bars will be welded to the vertical bars and spaced so that openings do not exceed 32 square inches.

(f) Either door may be hung on the outside of the doorway. They will be hung so that the doorframe is not separated from the door casing.

(g) Door hinges will be installed so that doors cannot be removed without seriously damaging the door or door jam. All exposed hinge pins will be spot welded or branded to prevent removal. This is not required when safety stud hinges are used or when the hinge pins are on the inside of the doors. (A safety hinge has a metal stud on the face of one hinge leaf and a hole in the other leaf. As the door closes, the stud enters the hole and goes through the full thickness of the leaf. This creates a "bolting" or "locking" effect).

(h) The outer door will be secured by one high security, key-opened padlock. These padlocks will conform to military specifications MIL-P43607 (GL) (High Security Padlock). The changeable combination padlock for the inner door will conform to requirements of military specification FF-P-110, 1969.

(i) All locks will be used with a heavy steel hasp and staple. The hasp and staple will be attached with smooth headed bolts or rivets that go through the entire thickness of the door or door jam. They will be spot welded or branded on the inside of the door. Heavy duty hasps and staples attached so that they cannot be removed when the doors are closed are acceptable.

(2) Method 2- specimens must be stored within a safe or cabinet, when not in full view of person who has custody.

(a) One door will be hung that is made of solid core wood or metal or a barred door. The solid door will, at a minimum, have a high security dead bolt lock.

(b) Inside the room will be a safe, filing cabinet or metal wall locker that weighs at least 500 pounds or is secured to the structure of the building with a chain.

(c) If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. This bar will be locked with a 200 series padlock. Note: a hasp may be welded to the top drawer, but then only the top drawer may be utilized for temporary storage.

(d) All opening/closing of the safe/cabinet will be annotated on a SF 702 (Security Container Check Sheet).

E-10. Temporary Storage of Urine Specimens at the Unit Level (by the UPL).

- a.* A safe, secure filing cabinet, or metal wall locker will be used to store specimens. This container must be in a lockable room or office.
- b.* The safe or filing cabinet must weigh at least 500 pounds or be attached to the structure of the building with a chain.
- c.* If a filing cabinet is used, then a metal bar hasp will be attached to run the entire height of the cabinet. Note: a hasp may be welded to the top drawer, but then only the top drawer may be utilized for temporary storage.
- d.* The safe or filing cabinet will have a key type padlock (with only 2 keys), which is used to secure the hasp.
- e.* One key will be issued to the primary UPL, the other key will be secured in a sealed envelope (signed by the key control custodian across the seal) and issued to the commander's safe. Both keys will be issued IAW key control SOPs.
- f.* All opening/closing of the safe/cabinet will be annotated on a SF 702.

E-11. Provisions

The provisions of this SOP (app. E) are not intended to, and do not, provide any rights or privileges as to the relevancy or admissibility of laboratory documents that are not otherwise afforded by the UCMJ, the Manual for Courts-Martial, or regulations governing adverse administrative and disciplinary actions. In no case will failure to comply with the provisions of this SOP be used to invalidate an otherwise valid and legally sufficient adverse administrative or disciplinary action.

Appendix F Program Evaluation Test Questions

F-1. Objective

The objective of these test questions is to assist unit managers and Alcohol and Drug Control Officers (ADCOs) in evaluating the ASAP.

F-2. Test Questions on Prevention of Abuse

- a.* Is an ADCO position authorized on the TDA and filled full time to implement the ASAP?
- b.* Are elements of prevention included in the ADCO position description?
- c.* Are the following essential prevention activities fully functional? (Note: Prevention activities are based on an installation's needs assessment.)
 - (1) Educating commanders about the ASAP?
 - (2) ASAP professional staff development?
 - (3) Civilian employee ASAP education?
 - (4) Family member ASAP education?
 - (5) Community awareness education on the ASAP?
 - (6) Unit education programs on the ASAP.
- d.* Is Alcohol and Drug Abuse Prevention Training (ADAPT) implemented in accordance with AR 600-85 and ACSAP standards?
- e.* Is ADAPT offered a minimum of once monthly?

F-3. ASAP Operations

- a.* Does the ADCO brief the Installation Commander on the overall ASAP status quarterly?
- b.* Are new commanders briefed on the ASAP upon assuming command?
- c.* Have unit alcohol and drug coordinators received training during the last year?
- d.* Have alcohol/drug articles been published (or radio/television/ electronic media announcements made) to support and inform on the ASAP and its programs?
- e.* Were prevention campaigns conducted, such as Drunk and Drugged Driving Awareness and Red Ribbon?

F-4. Identification of Abuse

- a.* Is the Medical Review Officer (MRO) appointed on orders signed by the Medical Treatment Facility (MTF) commander?
- b.* Has the MRO attended formal MRO training?
- c.* Is there an Installation Biochemical Testing Coordinator (IBTC) and alternate IBTC appointed on orders signed by the ADCO?
- d.* Have the IBTC and alternate IBTC attended and passed the ACSAP IBTC Course?
- e.* Is there a written collection SOP?

- f.* Is there a written SOP that covers IBTC administrative and operational procedures?
- g.* Has the ASAP evidence storage area passed a physical security inspection within the past year?
- h.* Are unit collections for all units inspected a minimum of twice annually by the IBTC or designee?
- i.* Is there a notification procedure for military personnel that includes the commander sending laboratory positives for amphetamines, barbiturates, or opiates to the MRO for final determination of legitimate use versus nonprescribed?
- j.* Are all patients identified through medical channels as having a drug or alcohol related diagnosis or related incident resulting in medical treatment referred to the ASAP?
- k.* Are appropriate reports (MP blotters, Serious Incident Reports) reviewed on a daily/weekly basis?
- l.* Are rehabilitation clients being periodically drug tested through the ASAP?
- m.* Are rehabilitation drug test properly coded on the chain of custody form?
- n.* Are copies of DA Form 4465, DA Form 4466; and data for completion of DA Form 3711 provided to the ADCO by the clinical staff?
- o.* Are DA Forms 4465, 4466, and 3711 completed and forwarded to ACSAP?
- p.* Is there an active DA civilian employee drug testing program?
- q.* Has a DA Form 5019 and/or a DA Form 7412 been signed by all civilians occupying a position requiring alcohol and/or other drug testing?
- r.* Are all supervisors trained at least annually on techniques for identifying abusers, the dangers of “enabling” and the referral process?
- s.* Are commanders conducting unannounced drug testing?
- t.* Have commanders been trained in “smart testing” techniques?

F–5. Rehabilitation and Treatment (to be completed by the Clinical Director)

- a.* Are face-to-face rehabilitation team meetings conducted with commanders for each soldier screened?
- b.* Have effective procedures been developed and implemented to ensure that the original of DA Forms 4465 and 4466 are forwarded to ACSAP?
- c.* Have effective procedures been developed and implemented to ensure that the ADCO is provided a copy of all DA Forms 4465 and 4466?
- d.* Have effective procedures been developed and implemented to ensure that the ADCO is provided all data required for completion of the DA Form 3711?
- e.* Have effective procedures been developed and implemented to ensure that rehabilitation urine testing is accomplished on all soldiers enrolled in the ASAP?
- f.* Has an effective monitoring procedure been implemented to ensure that results of all rehabilitation urine testing are provided to the appropriate counselor?
- g.* Has an effective monitoring procedure been implemented to ensure that open file cases on soldiers who are in a permanent change of station status are forwarded to the gaining ASAP?
- h.* Does ASAP check with ACSAP for prior enrollment information on soldiers currently evaluated and/or enrolled?
- i.* Is a DA Form 4466 completed and forwarded to ACSAP for each soldier in a PCS loss or gain status?
- j.* Have effective procedures been implemented to ensure that the ADCO is provided a copy of this rehabilitation and treatment review?

F–6. Program Evaluation

- a.* Have local statistics been maintained and analyzed for program needs and trends?
- b.* Has an Alcohol and Drug Intervention Council (ADIC) or similar forum been established to review current installation issues and trends?
- c.* Does the ADIC meet, at a minimum, on a quarterly basis?
- d.* Are “pre” and “post” tests utilized for ADAPT to assist in determining effectiveness of training?
- e.* Are evaluation forms on course content used for all training?
- f.* Are instructor evaluation forms used for all presentations?
- g.* Has the Federal Drug-free Workplace Program Report been submitted to ACSAP to provide statistical information on the civilian (DFW) drug-testing program?
- h.* Is the Office of Personnel Management (OPM) Federal Employee Counseling Program Report prepared and forwarded to HQDA annually?
- i.* Have monthly reports been submitted on DA Form 3711-R to ACSAP to provide statistical status on the ASAP?
- j.* Have goals and objectives been formulated in a written plan for a comprehensive installation prevention plan?
- k.* Is the ADCO provided a copy of the internal rehabilitation and treatment review?
- l.* Has the ADCO developed and implemented a plan to access and monitor command utilization of and satisfaction with all aspects of the program (that is, prevention, identification, rehabilitation, and treatment)?

Glossary

Section I Abbreviations

ACSAP

Army Center for Substance Abuse Programs

AD

Active Duty

ADAPT

Alcohol Drug Abuse Prevention Training

ADCO

Alcohol Drug Control Officer

ADIC

Alcohol Drug Intervention Council

ADT

Active Duty Training

AEP

ASAP Evaluation Plan

AMEDD

Army Medical Department

AMEDDC&S

AMEDD Center and School

ARNG

Army National Guard

AR-PERSCOM

USAR Personnel Command

ASAP

Army Substance Abuse Program

CAR

Chief, Army Reserve

CCF

Central Clearance Facility

CD

Clinical Director

CFR

Code of Federal Regulations

CNGB

Chief, National Guard Bureau

CONUS

Continental United States

COR

Contracting Officer's Representative

CPAC

Civilian Personnel Advisory Center

CPOC

Civilian Personnel Operations Center

DA

Department of the Army

DAMIS-HQ

Drug and Alcohol Management Information System-Headquarters

DAMIS-FS

Drug and Alcohol Management Information System-Field System

DCPDS

Defense Civilian Personnel Data System

DCSPER

Deputy Chief of Staff for Personnel

DFW

Drug-free Federal Workplace

DHHS

Department of Health and Human Services

DHR

Director of Human Resources

DOD

Department of Defense

DOT

Department of Transportation

EAP

Employee Assistance Program

EAPA

Employee Assistance Program Administrator

EAPC

Employee Assistance Program Coordinator

FAA

Federal Aviation Administration

FHWA

Federal Highway Administration

FTDTL

Forensic Toxicology Drug Testing Laboratory

HQDA

Headquarters, DA

HRC

Human Resource Council

IADT

Initial Active Duty Training

IBAT

Installation Breath Alcohol Technician

IBTC

Installation Biochemical Test Coordinator

IDT

Inactive Duty Training

IPP

Installation Prevention Plan

IPT

Installation Prevention Team

IPTT

Installation Prevention Team Training

LSD

Lysergic Acid Diethylamide

MACOM

Major Army Command

MEDCEN

Medical Center

MEDDAC

Medical Department Activity

MP

Military Police

MRE

Military Rules of Evidence

MRO

Medical Review Officer

MSC

Major Subordinate Command

MTF

Medical Treatment Facility

MUSARC

Major U.S. Army Reserve Command

NGB

National Guard Bureau

NGB-CD

National Guard Bureau, Counterdrug Directorate

OCONUS

Outside CONUS

ONDCP

Office of National Drug Control Policy

OPD

Official Personnel Folder

ODCSPER

Office of the Deputy Chief of Staff Personnel

PC

Prevention Coordinator

PCP

Phencyclidine

PERSCOM

Total Army Personnel Command

PL

Public Law

PM

Provost Marshal

PPA

Prevention Program Administrator

PRP

Personnel Reliability Program

RMC

Regional Medical Command

RRP

Risk Reduction Program

SAP

Substance Abuse Professional

SAV

Site Assistance Visit

SJA

Staff Judge Advocate

TDP

Testing Designated Position

TJAG

The Judge Advocate General

TRADOC

Training and Doctrine Command

TSG

The Surgeon General

UCMJ

Uniform Code of Military Justice

UPL

Unit Prevention Leader

USAAMC

U.S. Army Aeromedical Center

USACE

U.S. Army Corps of Engineers

USACIDC

U.S. Army Criminal Investigation Command

USAMEDCOM

U.S. Army Medical Command

USAR

U.S. Army Reserve

VA

Veterans Administration

Section II**Terms****Army Substance Abuse Program (ASAP)**

A personnel program that includes prevention, identification, education, and rehabilitation services. The program includes nonresidential and partial inpatient care program. The ASAP is responsive to the chain of command and supports the morale, safety, and combat readiness of the Army.

ASAP Records

Forms, records, or other documents required by this regulation. This includes any information, whether recorded or not, relating to a patient or client which is received or acquired in connection with any function of the ASAP, including evaluation for possible enrollment in the ASAP. Creation or maintenance of alcohol or other drugs abuse records that would identify an individual as client/patient of the ASAP, other than as required by this regulation, are prohibited.

Air Blank

A reading by an evidential breath test of ambient air containing no alcohol.

Alcohol Abuse

Any irresponsible use of an alcoholic beverage which leads to misconduct, unacceptable social behavior, or impairment of an individual's performance of duty, physical or mental health, financial responsibility, or personal relationships.

Alcohol Level

The alcohol in a volume of breath expressed in terms of grams of alcohol per 210 liters of breath as indicated by an evidential breath test. For example, a breath alcohol concentration of 0.04 means 0.04 grams (four one-hundredths of one gram) of alcohol in 210 liters of expired deep lung air.

Alcoholism

A treatable, progressive condition or illness characterized by excessive consumption of alcohol to the extent that the individual's physical and mental health, personal relationships, social conduct, or job performance are impaired.

Alcohol and Drug Control Officer (ADCO)

The person having staff responsibility for implementing, operating, and monitoring the ASAP at MACOM, installation, or major tenant unit level.

Chain of Custody

Procedures to account for the integrity of each urine specimen or aliquot, by tracking, handling, and storing from point of specimen collection to the final disposition of the specimen. Documentation of this process must include the date and purpose each time a specimen or aliquot is handled or transferred and identification of each individual in the chain of custody.

Confirmation

The process of using a second analytical procedure to identify the presence of a specific drug or metabolite that is independent of the initial test and which uses a different technique and chemical principle from that of the initial test in order ensure reliability and accuracy.

Drug Abuse

The use or possession of controlled substances, or illegal drugs, or the nonmedical or improper use of other drugs (for example, prescription, and over the and so forth.) that are packaged with a recommended safe dosage. That include the use of substances for other than their intended use (for example, glue and gasoline fume sniffing or steroid use for other than that which is specifically prescribed by competent medical authority.

Evidential Breath Testing (EBT) Device

A device approved by the National Highway Traffic Safety Administration (NHTSA) for the evidential testing of breath and placed on NHTSA's "Conforming Products List (CPL) of Evidential Breath Measurement Devices."

Enrollment

The formal action taken by an ASAP clinician, in consultation with the commander, to enter a soldier into the ASAP.

Family Member

Spouse or minor children of a soldier, or a DA civilian employee. Use of term in this regulation is intended to include only persons eligible for ASAP services by law or regulation.

Follow-up Testing

Unannounced testing which may be administered during counseling or rehabilitation. It is not be confused with testing which is undertaken as part of rehabilitation or counseling (that is, rehabilitation testing). Only verified results of follow-up testing may be used to support an adverse action.

Forensic

Suitable for a court of law, public debate, or argument.

Initial Test

A screening test to identify those specimens that are negative for the presence of drugs or their metabolites. When negative, these specimens need no further examination and need not undergo a more costly confirmation test.

Installation Breath Alcohol Technician (BAT)

An individual trained who instructs and assists employees/applicants in the alcohol testing process and operates an evidential breath test device.

Limited Use

Protection from the use of certain information, determined to be confidential by Federal regulation, to support disciplinary action under the UCMJ or administrative separation with a less than honorable discharge.

Medical Evaluation

Examination of an individual by a physician to determine whether there is evidence of alcohol or other drug abuse or dependency.

Medical Review Officer (MRO)

A licensed physician responsible for receiving laboratory results generated from a drug test who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate employees/applicant's confirmed positive tests results together with their medical histories and any other relevant biomedical information.

Prevention Procedures

Those actions designed to increase the likelihood that individuals will make responsible decisions regarding the use of alcohol or other drugs. Those actions taken to eliminate to the extent possible abuse or misuse of alcohol or other drugs.

Random Testing

Testing which occurs without suspicion that a particular individual is using illegal drugs.

Reasonable Suspicion

An articulable belief that an employee uses illegal drugs or misuses alcohol from specific and particularized facts and reasonable inferences from those facts.

Rehabilitation Team

A coordinating group consisting of the soldier, the unit commander and/or First Sergeant, the ASAP clinical staff, and other appropriate personnel as required (for example, clinical director, chaplain, physician, and so forth). The team reviews all pertinent information about the soldier and recommends to the commander when rehabilitation is required. It selects the appropriate rehabilitation track and assists the commander in setting standards of behavior and goals for evaluation of the soldier's progress in rehabilitation.

Sensitive Position

Any position within Department of the Army in which the occupant could cause, by virtue of the nature of the position, a materially adverse effect on the national security.

Employee Assistance Program Short-Term Counseling

The process whereby the Employee Assistance Program Coordinator provides short-term guidance, advice, education, and mediation to civilian employees towards resolution of employee problems and issues.

Split Specimen

An additional specimen collected with the original specimen to be tested in the event the original specimen tests positive.

Testing Designated Position (TDP) employee

A DA employee who holds a position identified by the Army as having critical safety or security responsibilities related to the Army mission.

Section III**Special Abbreviations and Terms**

There are no entries in this section.

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